

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7121

CERTIFICATE OF DEATH

Reg. Dist. No.

07104

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Murkirk, Md c. LENGTH OF STAY IN 1b 77 d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION Prince Georges General Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Murkirk, Md. d. STREET ADDRESS Cheverly, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles T. Adams First Middle Last 4. DATE OF DEATH June 6 1958 Month Day Year		5. SEX Male 6. COLOR OR RACE colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3/14/? 9. AGE (In years last birthday) 77 10. IF UNDER 1 YEAR Months Days Hours Min. 6 58 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Md 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alexander Adman 14. MOTHER'S MAIDEN NAME Catharine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Calvin Adams 17. INFORMANT Murkirk Md Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left cerebral infarction DUE TO 3 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerosis DUE TO 7 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 5/12 , 19 58 to 6/6 , 19 58 , that I last saw the deceased alive on 6/6 , 19 58 , and that death occurred at 11:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St. DATE SIGNED 6/6/58 ACTUAL SIGNATURE Norman Donat Cimeau M.D. PHYSICIAN'S NAME (Type) NORMAN DONAT CIMEAU Murkirk Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-10-58 22b. DATE THEREOF Queen Chapel 22c. NAME OF CEMETERY OR CREMATORY Murkirk Md 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE Harry S. Washington 467 N St N.W. ADDRESS 24a. REGISTRY REGISTRAR June 12 1958 DATE 24b. REGISTRAR'S SIGNATURE W. S. Smith	

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James W. Thompson
6-10-28 Queen Chapel
Staircase

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07105

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

M

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 3210 Perry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) George Edward Ager			4. DATE OF DEATH Month June Day 30 Year 1958		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-09		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Iron Works		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Ager		
14. MOTHER'S MAIDEN NAME Annie Bell			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 709-09-1899		
16. SOCIAL SECURITY NO. 709-09-1899			17. INFORMANT Edith Ager; same address as #2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar Manor, Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, N.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 30, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REGISTRAR'S SIGNATURE W. E. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07106

7183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1508 5th St., N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last E. Maud Anderson				4. DATE OF DEATH Month Day Year 6 30 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/5/1909	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Mrs. Pearl Mesta 1000 Fox Hall, N. W. Washington, D. C.		9. AGE (In years last birthday) 49 yrs.		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME James E. Anderson				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465x Pulmonary tuberculosis ***** DUE TO Pulmonary embolus, right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 9 yrs., 6 mos., 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Pulmonary tuberculosis, 9 yrs., 6 months				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/20, 19 49, to 6/30, 19 58, that I last saw the deceased alive on 6/30, 19 58, and that death occurred at 6:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss, M. D. Glenn Dale Hospital 6/30/58 PHYSICIAN'S NAME (Type) Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Saloon		22d. LOCATION (City, town, or county) (State) Middleburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Morris Roper Middleburg, Va.				24a. REC'D BY REGISTRAR DATE JUL 3 58		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7123

CERTIFICATE OF DEATH

07107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Charlestown Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Allen Last Baker				4. DATE OF DEATH Month June Day 28 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-90	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Marie T Baker North Beach, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis due to anemia 260 X DUE TO INTERCAPILLARY GLOMERULO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DIABETES MELLITIS (c) 10 YEARS							INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 55 to June 28, 19 58 that I last saw the deceased alive on June 28, 19 58 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. D. Dornier M.D.				ADDRESS (Street, city or town, state) 3503 Penny St		DATE SIGNED 6/28/58	
PHYSICIAN'S NAME (Type) Wm. D. Dornier				M.D. Wm. D. Dornier			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JUL 3	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07108

7184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b. <u>2 months and 16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>918 8th St., S. E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>-</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>19 58</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Separated</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/02</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johnnie Warren, Alexandria/ South Carolina Va., (landscaping)</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jim Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Byrd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>250-12-4819</u>		17. INFORMANT <u>Decedent</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma, left lung, with metastasis to ribs and chest wall</u> DUE TO (c) <u>7 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>58</u> , to <u>6/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>58</u> , and that death occurred at <u>11:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>6/11/58</u> ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale, Md.</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-13-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>not known as yet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Johnson</u> <u>Johnson & Perkins</u>				ADDRESS <u>4804 Ga. Ave</u>		24a. REC'D BY REGISTRAR <u>JUN 17 58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write SUBAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights	
3. NAME OF DECEASED (Type or print) First Charles Middle Benjamin Last Beall		4. DATE OF DEATH Month June Day 1, Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-58
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		9b. KIND OF BUSINESS OR INDUSTRY -----	9c. AGE (In years last birthday) yrs. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	10c. BIRTHPLACE (State or foreign country) Maryland
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Beall		14. MOTHER'S MAIDEN NAME Norma King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Beall; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 1, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 3, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR JUN 5 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

3516

Figure 1

10. *Journal of the American Medical Association*, 277:1033-1034, 1996

John W. Johnson, Editor

of earth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7185

CERTIFICATE OF DEATH

Reg. Dist. No. 07110

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia				c. LENGTH OF STAY IN 1b 22 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8161 - Riverview Road S.E.				d. STREET ADDRESS 8161- Riverview Road S.E.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GOLDIE Middle R. Last BERRY				4. DATE OF DEATH Month June Day 2nd. Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9th 1893	
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Silesia, Maryland.	
13. FATHER'S NAME William Raum				14. MOTHER'S MAIDEN NAME Laura Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Samuel S. Berry 8161- Riverview Road S.E. (Hus)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 174x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cancerous of the Uterus & Metastasis of Bladder DUE TO (c) Secondary Anaemia						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 yrs 2 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 19 57 to May 23 19 58 , that I last saw the deceased alive on May 23 19 58 , and that death occurred at 11 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Anna Coyne Todd M.D. 7519 Broadview Rd S.E. D.C. 22 6/2/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 4- 58				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington - Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros 1661- 9th Hope Rd & E				24a. REC'D BY REGISTRAR June 4 '58		24b. REGISTRAR'S SIGNATURE Arthur Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7186
CERTIFICATE OF DEATH

Reg. Dist. No. 07111

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. LENGTH OF STAY IN 1b 2 1/2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Marianne Court		e. STREET ADDRESS 11 Marianne Court	
3. NAME OF DECEASED (Type or print) First Harold Middle M. Last Bower		4. DATE OF DEATH Month June Day 25 Year 19 58.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Guard		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government (G.S.A.)	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James B. Bower		14. MOTHER'S MAIDEN NAME Laura Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Harry W. Bower Address Mr. & Mrs. Harold (Son) (-same as above.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric ulcer		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9 , 19 58 to 6-25 , 19 58 , that I last saw the deceased alive on 6-23 , 19 58 , and that death occurred at 1:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4223 Silver Hill Rd., Silver Hill, Maryland. DATE SIGNED 6/26/58			
ACTUAL SIGNATURE John P. D'Angelo, M.D.		PHYSICIAN'S NAME (Type) John P. D'Angelo, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.-Upper Marlboro, Maryland		24a. REC'D BY REGISTRAR JUL 1 24b. REGISTRAR'S SIGNATURE W. S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7122

John T. Linder, Jr.

White

24 Years

White

11 months

11 months

White

White

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

11 months

07112

7125

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 817 Montgomery Rd.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENNING Last BOYLE, SR.				4. DATE OF DEATH Month June Day 10 Year 19 58	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/26/93		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John S. Boyle			
14. MOTHER'S MAIDEN NAME Erma Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Pneumonia, arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 14 hrs. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1956 , to July 10, 1958 , that I last saw the deceased alive on July 10, 1958 , and that death occurred at 10 15 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 3408 Rhode Island M Trainor, Md DATE SIGNED ACTUAL SIGNATURE Dr. W. L. Connelley, MD M.D. PHYSICIAN'S NAME (Type) 1					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial June 12, 1958		June 12, 1958		Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. W. L. Connelley		ADDRESS Laurel Md		24a. REC'D BY REGISTRAR DATE JUN 18 1958	
24b. REGISTRAR'S SIGNATURE W. L. Connelley					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07113

7126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood 34 d. STREET ADDRESS 4316 40th pl. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Fitch Brinson		4. DATE OF DEATH Month Day Year June 29 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert C. Fitch		14. MOTHER'S MAIDEN NAME Ida Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Brinson		Address Brentwood, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC VALVULAR DISEASE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 19 56 to June 29, 19 58 , that I last saw the deceased alive on June 29, 19 58 , and that death occurred at 2:27 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman L. Comeau		ADDRESS (Street, city or town, state) 3503 Perry St. DATE SIGNED 6/29/58	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau		M.D. MT Comeau MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 2, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE JUL 2 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07114

Reg. Dist. No.

7127

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington D C COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b plead in small	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Brown		4. DATE OF DEATH Month June Day 1, Year 1958-	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 14, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car washer		10b. KIND OF BUSINESS OR INDUSTRY National Car Wash co	9. AGE (in years last birthday) 34 yrs.
11. BIRTHPLACE (State or foreign country) Lawndale N C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT George W Brown		Address 2426 15th Place S E	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823x Hemorrhage and shock DUE TO (b) Fracture of base of skull Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Washington D C			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto that ran off Road	
20c. TIME OF INJURY Month, Day, Year June 6-1 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 4		20f. (City or town) (State) Forestville Pg Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 1, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/2/58	
22c. NAME OF CEMETERY OR CREMATORY W.ERNEST JARVIS CO. 1432 YOU St, NW (Wash) DC		22d. LOCATION (City, town, or county) (State) SHELBY N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.ERNEST JARVIS CO. 1432 YOU St, NW (Wash) DC		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
		24b. REGISTRAR'S SIGNATURE W. Ernest Jarvis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
MAY 19 1961

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased <i>George W. Brown</i>		Sex <i>Male</i>		Age <i>68</i>	
Date of Death <i>May 10, 1961</i>		Place of Death <i>Home</i>		Residence <i>1000 N. ...</i>	
Cause of Death <i>Myocardial Infarction</i>		Manner of Death <i>Natural</i>		Occupation <i>Retired</i>	
Physician's Name <i>Dr. ...</i>		Hospital Name <i>None</i>		Medical History <i>None</i>	
Signature of Physician <i>[Signature]</i>		Signature of Medical Examiner <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>	
Date of Signature <i>May 10, 1961</i>		Date of Signature <i>May 10, 1961</i>		Date of Signature <i>May 10, 1961</i>	

7110

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 7 years.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5901 Knollbrook Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle WILKINS Last BURNETT		4. DATE OF DEATH Month June Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/98
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - painter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Wilkins Burnett.		14. MOTHER'S MAIDEN NAME Ella Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 414-46-7330	
17. INFORMANT Nell Burnett-wife		Address - Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Immed. 1 1/2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pulmonary emphysema - severe.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from January , 19 57 , to Present , 19 58 , that I last saw the deceased alive on May 12 , 19 58 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Simpson Jr.		DATE SIGNED 6/6/58	
PHYSICIAN'S NAME (Type) WILLIAM F SIMPSON JR.		ADDRESS (Street, city or town, state) 6216 N. H. Ave N.E. Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 6/7/58	22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	22d. LOCATION (City, town, or county) (State) Chattanooga, Tenn.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR JUN 9 '58	
24b. REGISTRAR'S SIGNATURE W. H. Hines			

Coroner Notified and will approve - *W. H. Hines*

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

NAME OF DECEASED George Washington		AGE 70 years	
SEX Male		RACE White	
DATE OF DEATH April 15, 1910		PLACE OF DEATH Home	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		COUNTRY United States	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
DISEASE Coronary Artery Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED George Washington	
SIGNATURE OF WITNESSES J. H. Smith, M.D. J. H. Smith, M.D.		SIGNATURE OF DECEASED George Washington	
DATE OF DEATH April 15, 1910		PLACE OF DEATH Home	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		COUNTRY United States	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
DISEASE Coronary Artery Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED George Washington	
SIGNATURE OF WITNESSES J. H. Smith, M.D. J. H. Smith, M.D.		SIGNATURE OF DECEASED George Washington	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
c. LENGTH OF STAY IN 1b <u>20 hours</u>		d. STREET ADDRESS <u>Croom Station Road</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac</u>		4. DATE OF DEATH <u>June 16 1958</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>Celred</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5 1896</u>	
9. AGE (In years last birthday) <u>63</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Burroughs</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>alphonso Burroughs</u>	
17. INFORMANT <u>alphonso Burroughs</u>		Address <u>Heanwood Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Compound fracture of right leg</u> (a), stating the underlying cause last. (c) <u>Crushed chest, Ruptured diaphragm</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>16</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by an automobile</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:20 a.m. 6-16 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 4</u>		20f. (City or town) <u>Upper Marlboro Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE THEREOF <u>6-20-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>	
22b. DATE THEREOF <u>6-20-58</u>		22d. LOCATION (city, town, or county) <u>Arlington Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Collins</u>		24a. REC'D BY REGISTRAR <u>JUN 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>		24c. DATE <u>JUN 20 '58</u>	

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117

7129

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4609 Oliver Street</u>				d. STREET ADDRESS <u>4609 Oliver St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hazel Rebecca Calhoun</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-94</u>	
9. AGE (In years last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C., U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. William Calhoun</u>				14. MOTHER'S MAIDEN NAME <u>Fannie M. Calhoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>MC</u>		17. INFORMANT <u>Fannie Calhoun</u> Address <u>Same address.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 23, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>Wash. D. C.</u> <u>2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO		c. LENGTH OF STAY IN 1b 1 YEAR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4000 OLD MILL ROAD		d. STREET ADDRESS 116 BRYANT ST. N.W.	
3. NAME OF DECEASED (Type or print) First ROSA Middle ETTA Last CATER		4. DATE OF DEATH Month JUNE Day 17 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10b. KIND OF BUSINESS OR INDUSTRY NURSING	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME SIMON HOWARD		14. MOTHER'S MAIDEN NAME MOLLY RAGLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOSEPH CATER (SON)		Address 4000 OLD MILL RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO INANITION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF THE BLADDER DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 12 MOS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT. 1957 to JUNE 12, 1958 that I last saw the deceased alive on JUNE 12, 1958 , and that death occurred at 12:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Chet M. Cadenhead		ADDRESS (Street, city or town, state) 3904 ELM ST. UPPER MARLBORO DATE SIGNED 6-17-58	
PHYSICIAN'S NAME (Type) —			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/21/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Akron, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE JUN 19 '58	24b. REGISTRAR'S SIGNATURE —

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7111

CERTIFICATE OF DEATH

07119

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				d. STREET ADDRESS 13503 Metzrott Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVY NELSON CAVILEER				4. DATE OF DEATH Month Day Year June 8 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Peter Cavileer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Gilbert Cavileer College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arterio-sclerotic cardio-vascular disease (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to June 1958, that I last saw the deceased alive on June 7, 1958, and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. L. Etienne				ADDRESS (Street, city or town, state) 4713-Berwyn Rd College Park, Md		DATE SIGNED 6/8/58	
PHYSICIAN'S NAME (Type) W. L. ETIENNE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORY Greenlawn		22d. LOCATION (City, town, county) (State) Newport News Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Susch sons Hyattsville Md				24a. REC'D BY REGISTRAR JUN 11 1958		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07120

7188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		d. STREET ADDRESS <u>314 1/2 G. St., S. E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Delores</u> Middle <u>M.</u> Last <u>Chambliss</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>5/24/34</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Shelby</u>		14. MOTHER'S MAIDEN NAME <u>Leslie M. Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>579-40-3483</u>	
17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs., 9 mos.,</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. p.</u> Month, Day, Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>56</u> , to <u>6/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>58</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Moe Weiss</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Glenn Dale Hospital</u> <u>6/23/58</u>	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		<u>Glenn Dale, Md.</u>	
22a. CREMATION CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer Funeral Home 412 H St NE.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 10 1918	
PLACE OF DEATH HOME		CITY BALTIMORE	
AGE 45		SEX MALE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH JAN 10 1873		PLACE OF BIRTH BALTIMORE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		MILITARY SERVICE NONE	
PREVIOUS ILLNESS NONE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESS JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN JAMES H. HARRIS		SIGNATURE OF CLERK JAMES H. HARRIS	
SIGNATURE OF MINISTER JAMES H. HARRIS		SIGNATURE OF JURY JAMES H. HARRIS	
SIGNATURE OF CORONER JAMES H. HARRIS		SIGNATURE OF JUDGE JAMES H. HARRIS	
SIGNATURE OF SHERIFF JAMES H. HARRIS		SIGNATURE OF CLERK JAMES H. HARRIS	
SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESS JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN JAMES H. HARRIS		SIGNATURE OF CLERK JAMES H. HARRIS	
SIGNATURE OF MINISTER JAMES H. HARRIS		SIGNATURE OF JURY JAMES H. HARRIS	
SIGNATURE OF CORONER JAMES H. HARRIS		SIGNATURE OF JUDGE JAMES H. HARRIS	
SIGNATURE OF SHERIFF JAMES H. HARRIS		SIGNATURE OF CLERK JAMES H. HARRIS	

1918

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fairmount Heights</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715-58th ave, N.E.</u>				d. STREET ADDRESS <u>715-58th ave, N.E.</u>			
3. NAME OF DECEASED (Type or print) <u>MAL K I A H</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Malkiah</u>				14. MOTHER'S MARDEN NAME <u>Ida</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Leahy Margaret</u>		Address <u>Portville Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease acute</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Heart disease Mitral disease</u> (c) <u>1-11</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/9</u> , 1958, to <u>6/9</u> , 1958, that I last saw the deceased alive on <u>6/9/58</u> , 19, and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1107-0-58-N.W.-N.C.</u> <u>6-10-58</u>							
ACTUAL SIGNATURE <u>J. FRANCIS DYE R.</u>				M.D. <u>1107-0-58-N.W.-N.C.</u>			
PHYSICIAN'S NAME (Type) <u>J. FRANCIS DYE R.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Wilson + Woodford</u>				ADDRESS <u>1622-11th St NW</u>		24a. REGD BY REGISTRAR DATE <u>JUN 16 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

U.S. DEPARTMENT OF HEALTH—BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07122

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		c. LENGTH OF STAY IN 1b 6 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6808 Ritchie-Marlboro Road, S.E., Wash., D.C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Gertrude G. Clark			4. DATE OF DEATH Month June Day 23 Year 19 58.		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1882		9. AGE (In years last birthday) 76 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
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13. FATHER'S NAME Dr. Frank L. Gilbert		14. MOTHER'S MAIDEN NAME Kitturah Dawson	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -----		17. INFORMANT Dudley L. Clark		Address 7128 Marlboro Pike, S.E. District Hghts., Md.	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Congestive heart failure DUE TO (b) Cardiovascular Renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from June 9, 1958 to June 23, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 9:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forestville, Maryland. DATE SIGNED 6/23/58.	
ACTUAL SIGNATURE James I. Boyd M.D.	
PHYSICIAN'S NAME (Type) James I. Boyd, M.D.	

22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58:		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery.		22d. LOCATION (City, town, or county) (State) Smyrna, Delaware.	
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23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		ADDRESS Upper		24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE Al. Leach	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

NAME OF DECEASED

LAST NAME

FIRST NAME

MIDDLE NAME

AGE

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

DATE OF EXAMINATION

PLACE OF EXAMINATION

CITY

COUNTY

STATE

DATE OF REPORT

PLACE OF REPORT

CITY

COUNTY

STATE

DATE OF ENTRY

PLACE OF ENTRY

CITY

COUNTY

STATE

DATE OF FILING

PLACE OF FILING

CITY

COUNTY

STATE

DATE OF REGISTRATION

PLACE OF REGISTRATION

CITY

COUNTY

STATE

DATE OF CORRECTION

PLACE OF CORRECTION

CITY

COUNTY

STATE

DATE OF AMENDMENT

PLACE OF AMENDMENT

CITY

COUNTY

STATE

DATE OF CANCELLATION

PLACE OF CANCELLATION

CITY

COUNTY

STATE

DATE OF REVISION

PLACE OF REVISION

CITY

COUNTY

STATE

DATE OF SUPPLEMENT

PLACE OF SUPPLEMENT

CITY

COUNTY

STATE

DATE OF ADDENDUM

PLACE OF ADDENDUM

CITY

COUNTY

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DATE OF EXHIBIT

PLACE OF EXHIBIT

CITY

COUNTY

STATE

DATE OF ANNEX

PLACE OF ANNEX

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DATE OF EXHIBIT

PLACE OF EXHIBIT

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COUNTY

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DATE OF ANNEX

PLACE OF ANNEX

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COUNTY

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DATE OF SUPPLEMENTAL

PLACE OF SUPPLEMENTAL

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PLACE OF AMENDMENT

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DATE OF CORRECTION

PLACE OF CORRECTION

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COUNTY

STATE

DATE OF REVISION

PLACE OF REVISION

CITY

COUNTY

STATE

DATE OF SUPPLEMENT

PLACE OF SUPPLEMENT

CITY

COUNTY

STATE

CERTIFICATE OF DEATH

Reg. Dist. No. 07123

7130

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Leland Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. NAME OF DECEASED (Type or print) <i>John Ralph Clarke</i>				4. DATE OF DEATH <i>June 21 1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 11, 1882</i>	
9. AGE (In years last birthday) <i>76</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Rufus King Clarke</i>				14. MOTHER'S MAIDEN NAME <i>Nell Greenwell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>		17. INFORMANT <i>Chas. Clarke</i> Address <i>6026 Mustang Dr. Riverdale, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Cerebral Thrombosis</i> DUE TO (c) <i>Hypertensive-Cardio-vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>2-4 hours</i> <i>9 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12 June 1958</i> , to <i>21 June 1958</i> , that I last saw the deceased alive on <i>20 June 1958</i> , and that death occurred at <i>9:40 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7315 Landonover Rd. Hyattsville, Md.</i> DATE SIGNED <i>6-21-58</i>							
ACTUAL SIGNATURE <i>Thos M. Hutchins</i>				M.D. <i>Thos M. Hutchins</i>			
PHYSICIAN'S NAME (Type) <i>Thos M. Hutchins</i>				ADDRESS <i>131-14th St. Wash, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6-24-1958</i>		<i>Washington Natl</i>		<i>Smithland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A Mattingly</i>				ADDRESS <i>131-14th St. Wash, D.C.</i>		24a. REC'D BY REGISTRAR <i>Albeaich</i>	
				DATE <i>JUN 24 '58</i>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7191
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND PARK				c. LENGTH OF STAY IN 1b 15 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 6902 "M" ST			
3. NAME OF DECEASED (Type or print) ADDIE First A. COCKRELL Middle Last				4. DATE OF DEATH Month JUNE Day 4 Year 1958			
5. SEX F.		6. COLOR OR RACE N.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 1, 1888	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 6 Days 9		IF UNDER 24 HRS. Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PREACHER				10b. KIND OF BUSINESS OR INDUSTRY PREACHER		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JACKSON				14. MOTHER'S MAIDEN NAME COCKRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT (HUSBAND) Address ASBURY COCKRELL 6902 "M" ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA DUE TO (c) LUES (CNS) INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 4 DAYS 2 YEARS?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from SEPT. 1956 , to JUNE 1958 , that I last saw the deceased alive on JUNE 4, 1958 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest M. Cadenhead				ADDRESS (Street, city or town, state) 7220 BOOKER DR. HUNTSVILLE AL.			
DATE SIGNED 17 D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-58		22c. NAME OF CEMETERY OR CREMATORY W. Oadham		22d. LOCATION (City, town, or county) (State) Wash DC	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Bacon				ADDRESS 1722 78th St		24a. REC'D BY REGISTRAR 1722 78th St	
				24b. REGISTRAR'S SIGNATURE 1722 78th St			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			e. STREET ADDRESS Route 2, Box 139		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Coleman			4. DATE OF DEATH Month Day Year June 12, 1958		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1889		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Coleman			14. MOTHER'S MAIDEN NAME Hester Shephard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Coleman, Jr., Same address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 12, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery	
22d. LOCATION (City, town, or county) Queen Anne District		(State) Prince Geo. County, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart		ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR JUN 16 1958	
24b. REGISTRAR'S SIGNATURE W. J. ...					

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased James S. Coleman, Jr.		Residence Hollywood, Maryland		Date of Death June 12, 1955	
Age 35		Sex Male		Race White	
Cause of Death Acute myocardial heart failure		Place of Death Home		Date of Birth June 12, 1920	
Signature of Physician John T. Wilkey, M.D.		Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	
Hospital or Institution None		Occupation None		Manner of Death Natural	
Medical History None		Social History None		Family History None	
Postmortem Examination None		Toxicology None		Other None	

7192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thelma</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillside, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1111-57 Ave Thelma Md</i>		d. STREET ADDRESS <i>1111-57 Ave</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLOTTE E. CONRAD</i>		4. DATE OF DEATH Month <i>6</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 4 - 1880</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>HENRY SMITH</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John R. Conrad</i>		Address <i>1111-57 Ave Thelma Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis Generalized</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema Pulmonary, Pulmonary Fibrosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1 Dec 1957</i> to <i>18 June 1958</i> that I last saw the deceased alive on <i>4 June 1958</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas P. Fogarty</i> M.D.		ADDRESS (Street, city or town, state) <i>1214 University Blvd E. Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS P. FOGARTY</i>		DATE SIGNED <i>18 June 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-21-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Luttwald Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Regina A. Walsh</i>		24a. RECEIVED BY REGISTRAR DATE <i>JUN 20 58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

Reg. Dist. No.

<p>1. Name of deceased</p> <p><i>John Doe</i></p>		<p>2. Sex</p> <p><i>Male</i></p>	
<p>3. Age</p> <p><i>45</i></p>		<p>4. Date of birth</p> <p><i>Jan 15 1870</i></p>	
<p>5. Place of birth</p> <p><i>England</i></p>		<p>6. Date of death</p> <p><i>Dec 10 1915</i></p>	
<p>7. Cause of death</p> <p><i>Heart disease</i></p>		<p>8. Place of death</p> <p><i>Home</i></p>	
<p>9. Signature of physician</p> <p><i>John Doe</i></p>		<p>10. Signature of registrar</p> <p><i>John Doe</i></p>	
<p>11. Signature of informant</p> <p><i>John Doe</i></p>		<p>12. Signature of witness</p> <p><i>John Doe</i></p>	
<p>13. Signature of registrar</p> <p><i>John Doe</i></p>		<p>14. Signature of witness</p> <p><i>John Doe</i></p>	
<p>15. Signature of registrar</p> <p><i>John Doe</i></p>		<p>16. Signature of witness</p> <p><i>John Doe</i></p>	
<p>17. Signature of registrar</p> <p><i>John Doe</i></p>		<p>18. Signature of witness</p> <p><i>John Doe</i></p>	
<p>19. Signature of registrar</p> <p><i>John Doe</i></p>		<p>20. Signature of witness</p> <p><i>John Doe</i></p>	
<p>21. Signature of registrar</p> <p><i>John Doe</i></p>		<p>22. Signature of witness</p> <p><i>John Doe</i></p>	
<p>23. Signature of registrar</p> <p><i>John Doe</i></p>		<p>24. Signature of witness</p> <p><i>John Doe</i></p>	
<p>25. Signature of registrar</p> <p><i>John Doe</i></p>		<p>26. Signature of witness</p> <p><i>John Doe</i></p>	
<p>27. Signature of registrar</p> <p><i>John Doe</i></p>		<p>28. Signature of witness</p> <p><i>John Doe</i></p>	
<p>29. Signature of registrar</p> <p><i>John Doe</i></p>		<p>30. Signature of witness</p> <p><i>John Doe</i></p>	
<p>31. Signature of registrar</p> <p><i>John Doe</i></p>		<p>32. Signature of witness</p> <p><i>John Doe</i></p>	
<p>33. Signature of registrar</p> <p><i>John Doe</i></p>		<p>34. Signature of witness</p> <p><i>John Doe</i></p>	
<p>35. Signature of registrar</p> <p><i>John Doe</i></p>		<p>36. Signature of witness</p> <p><i>John Doe</i></p>	
<p>37. Signature of registrar</p> <p><i>John Doe</i></p>		<p>38. Signature of witness</p> <p><i>John Doe</i></p>	
<p>39. Signature of registrar</p> <p><i>John Doe</i></p>		<p>40. Signature of witness</p> <p><i>John Doe</i></p>	
<p>41. Signature of registrar</p> <p><i>John Doe</i></p>		<p>42. Signature of witness</p> <p><i>John Doe</i></p>	
<p>43. Signature of registrar</p> <p><i>John Doe</i></p>		<p>44. Signature of witness</p> <p><i>John Doe</i></p>	
<p>45. Signature of registrar</p> <p><i>John Doe</i></p>		<p>46. Signature of witness</p> <p><i>John Doe</i></p>	
<p>47. Signature of registrar</p> <p><i>John Doe</i></p>		<p>48. Signature of witness</p> <p><i>John Doe</i></p>	
<p>49. Signature of registrar</p> <p><i>John Doe</i></p>		<p>50. Signature of witness</p> <p><i>John Doe</i></p>	
<p>51. Signature of registrar</p> <p><i>John Doe</i></p>		<p>52. Signature of witness</p> <p><i>John Doe</i></p>	
<p>53. Signature of registrar</p> <p><i>John Doe</i></p>		<p>54. Signature of witness</p> <p><i>John Doe</i></p>	
<p>55. Signature of registrar</p> <p><i>John Doe</i></p>		<p>56. Signature of witness</p> <p><i>John Doe</i></p>	
<p>57. Signature of registrar</p> <p><i>John Doe</i></p>		<p>58. Signature of witness</p> <p><i>John Doe</i></p>	
<p>59. Signature of registrar</p> <p><i>John Doe</i></p>		<p>60. Signature of witness</p> <p><i>John Doe</i></p>	
<p>61. Signature of registrar</p> <p><i>John Doe</i></p>		<p>62. Signature of witness</p> <p><i>John Doe</i></p>	
<p>63. Signature of registrar</p> <p><i>John Doe</i></p>		<p>64. Signature of witness</p> <p><i>John Doe</i></p>	
<p>65. Signature of registrar</p> <p><i>John Doe</i></p>		<p>66. Signature of witness</p> <p><i>John Doe</i></p>	
<p>67. Signature of registrar</p> <p><i>John Doe</i></p>		<p>68. Signature of witness</p> <p><i>John Doe</i></p>	
<p>69. Signature of registrar</p> <p><i>John Doe</i></p>		<p>70. Signature of witness</p> <p><i>John Doe</i></p>	
<p>71. Signature of registrar</p> <p><i>John Doe</i></p>		<p>72. Signature of witness</p> <p><i>John Doe</i></p>	
<p>73. Signature of registrar</p> <p><i>John Doe</i></p>		<p>74. Signature of witness</p> <p><i>John Doe</i></p>	
<p>75. Signature of registrar</p> <p><i>John Doe</i></p>		<p>76. Signature of witness</p> <p><i>John Doe</i></p>	
<p>77. Signature of registrar</p> <p><i>John Doe</i></p>		<p>78. Signature of witness</p> <p><i>John Doe</i></p>	
<p>79. Signature of registrar</p> <p><i>John Doe</i></p>		<p>80. Signature of witness</p> <p><i>John Doe</i></p>	
<p>81. Signature of registrar</p> <p><i>John Doe</i></p>		<p>82. Signature of witness</p> <p><i>John Doe</i></p>	
<p>83. Signature of registrar</p> <p><i>John Doe</i></p>		<p>84. Signature of witness</p> <p><i>John Doe</i></p>	
<p>85. Signature of registrar</p> <p><i>John Doe</i></p>		<p>86. Signature of witness</p> <p><i>John Doe</i></p>	
<p>87. Signature of registrar</p> <p><i>John Doe</i></p>		<p>88. Signature of witness</p> <p><i>John Doe</i></p>	
<p>89. Signature of registrar</p> <p><i>John Doe</i></p>		<p>90. Signature of witness</p> <p><i>John Doe</i></p>	
<p>91. Signature of registrar</p> <p><i>John Doe</i></p>		<p>92. Signature of witness</p> <p><i>John Doe</i></p>	
<p>93. Signature of registrar</p> <p><i>John Doe</i></p>		<p>94. Signature of witness</p> <p><i>John Doe</i></p>	
<p>95. Signature of registrar</p> <p><i>John Doe</i></p>		<p>96. Signature of witness</p> <p><i>John Doe</i></p>	
<p>97. Signature of registrar</p> <p><i>John Doe</i></p>		<p>98. Signature of witness</p> <p><i>John Doe</i></p>	
<p>99. Signature of registrar</p> <p><i>John Doe</i></p>		<p>100. Signature of witness</p> <p><i>John Doe</i></p>	

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of witness

13. Signature of registrar

14. Signature of witness

15. Signature of registrar

16. Signature of witness

17. Signature of registrar

18. Signature of witness

19. Signature of registrar

20. Signature of witness

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96. Signature of witness

97. Signature of registrar

98. Signature of witness

99. Signature of registrar

100. Signature of witness

7112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>2mo. 18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>L.</u> Middle <u>Counts Sr.</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1860</u>	9. AGE (In years last birthday) yrs. <u>98</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Elijah Shelby Counts</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rasnick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-24-5180A</u>		17. INFORMANT <u>Richard L. Counts Jr.</u> Address <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>3 DAYS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) <u> </u>		(County) <u> </u>	(State) <u> </u>
21. I certify that I attended the deceased from <u> </u> , 19 <u>53</u> , to <u>20 JUN</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NEAR - 20 JUNE, 1958</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>				ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST. HYATTSVILLE</u>			
DATE SIGNED <u>6/20/58</u>							
PHYSICIAN'S NAME (Type) <u>Henry R. Wolfe</u>				ADDRESS <u>905 Sheridan St. Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				ADDRESS <u>3821-14th St. N.W.</u> <u>Washington 11, DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1880		New York		New York		New York		United States	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL RESIDENCE		SPECIAL OCCUPATION	
White		White		Roman Catholic		Married		High School		Teacher		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
1925		New York		New York		New York		United States		Heart Disease		Natural		Dr. J. H. Smith	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		REPORTER		SIGNATURE		TITLE	
1925		New York		New York		New York		United States		J. H. Smith		[Signature]		Physician	

TO BE FILLED BY THE REPORTER OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
7132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07128

Reg. Disf. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Baltimore 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6715 Gary Avenue	
3. NAME OF DECEASED (Type or print) Robert Garpton Day		4. DATE OF DEATH June 15, 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-40
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk		10b. KIND OF BUSINESS OR INDUSTRY Rubber Hose	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Gordon Warfield Day		14. MOTHER'S MAIDEN NAME Catherine Zellers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-36-1395	
17. INFORMANT Gordon Day; same address as #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound, comminuted fracture of skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another.	
20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 6-14-58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Cheverly (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED June 15, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Colgate, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		ADDRESS	
24a. REC'D BY REGISTRAR JUN 18 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

First Name

Last Name

Address

City

Street

County

Age

Sex

Color

Marital Status

Occupation

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

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Signature

Signature

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Signature

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
c. LENGTH OF STAY IN 1b Head on arrival		d. STREET ADDRESS Rt # 2 Box 38	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mr. Johnsons Office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Phillip Lerizo Perry		4. DATE OF DEATH June 12 1958	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 7, 1954	
9. AGE (In years last birthday) 3 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) District of Columbia D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Lerizo Perry Sr		14. MOTHER'S MAIDEN NAME Mary Bernadine Russek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary B McCell, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Broncho pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) DUE TO (c) gave rise to the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 13, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) Arlington Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin Bros.		ADDRESS 1661 Wood Hyde Rd. SE Wash. DC	
24. REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE	
DATE JUN 16 '58			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07130

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swittland</u>	
c. LENGTH OF STAY IN 1b <u>Debarment</u>		d. STREET ADDRESS <u>4733 Homer Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara May Kelley</u>		4. DATE OF DEATH <u>June 15 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1887</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>6</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Festler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hamming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Walter Kelley same as #1</u>		Address <u>same as #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of left forearm</u> (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell in home and fractured forearm</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 5 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Swittland</u> (County) <u>PS</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/16/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill</u>		22d. LOCATION (City, town, or county) <u>Swittland, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc. Jr.</u>		ADDRESS <u>317 P. AVE., S. E</u>	
24a. REC'D BY REGISTRAR <u>June 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
7223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and printed form fields are visible throughout the page. The form includes sections for patient information, medical history, and cause of death.]

[Faint signature and stamp are visible at the bottom of the form.]

07131

7113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Baltimore, Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b 4 mo. 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		d. STREET ADDRESS 606 Springfield Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Elizabeth		First A.		Middle Doehler		Last	
4. DATE OF DEATH June		Month		Day 30		Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1870		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 3 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME John Engelhardt			14. MOTHER'S MAIDEN NAME Anna Yeakel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Sister Hyacinth, Sacred Heart Home, Hyattsville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, both lungs 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Feb. 6 , 19 58 to June 30 , 19 58 that I last saw the deceased alive on June 30 , 19 58 , and that death occurred at 4:05 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 322 H St NE DATE SIGNED 6/30/58							
ACTUAL SIGNATURE Thomas F Collins		M.D. Washington DC					
PHYSICIAN'S NAME (Type) Thomas F Collins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran -3000 E. Baltimore Street				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 3 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased JAMES A. HARRIS		2. Sex Male		3. Age 38	
4. Date of death July 8, 1970		5. Time of death 10:30 AM		6. Place of death Home	
7. Cause of death Myocardial infarction		8. Manner of death Natural		9. Signature of physician J. H. Smith	
10. Signature of registrar J. H. Smith		11. Date of registration July 10, 1970		12. Office of registration Baltimore, Maryland	

100

Original filed in Baltimore, Maryland
July 10, 1970
J. H. Smith

7194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) 6745 Prince George Drive S.E.				d. STREET ADDRESS 6745 Prince George Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mande Irene Donaldson				4. DATE OF DEATH Month Day Year June 28 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Saleslady		11. BIRTHPLACE (State or foreign country) Lorton, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank C. Clark				14. MOTHER'S MAIDEN NAME Marietta Burdette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 519-22-2740			
17. INFORMANT Address 732 Burrhead Rd. Falls Church, Va.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Uremia DUE TO Arterio-Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) Coronary Thrombosis 20 yrs. 27 yrs. 3 months							INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetic Cataracts							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1955, to 6-28, 1958, that I last saw the deceased alive on 6-27, 1958, and that death occurred at 6:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 7519 Broadview Rd. S.E.				DATE SIGNED 6/28/58			
ACTUAL SIGNATURE Anna Coyne Todd M.D.							
PHYSICIAN'S NAME (Type) Anna Coyne Todd D.C. 22							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1958		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Wash., D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 131-114 St. Wash., D.C.				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>An. Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i> HYSTONVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i> M.D.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5814 Ritchie Rd</i>		d. STREET ADDRESS <i>5814 Ritchie Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Amelia</i> First Middle Last <i>Ellis</i>		4. DATE OF DEATH <i>June 12 1958</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, 1880</i> AGE (In years last birthday) <i>77</i> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>England</i>
13. FATHER'S NAME <i>John T. Askey</i>		14. MOTHER'S MAIDEN NAME <i>Phoebe Flowers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT Address <i>Amelia P. Dickson - 5814 Ritchie Rd.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Failure</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Insufficiency</i> DUE TO (c) <i>Hypertensive Arterio Sclerotic HD 6 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 Days</i> <i>4 Months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sanity</i> <i>Age 77 - Parkinson's disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1</i> , 19 <i>55</i> , to <i>June 12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 7</i> , 19 <i>58</i> , and that death occurred at <i>9:15</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sidney W. Lowry</i> M.D.		ADDRESS (Street, city or town, state) <i>1200 MARLBORO PIKE SE</i>	
PHYSICIAN'S NAME (Type) <i>SIDNEY W. LOWRY M.D.</i>		DISTRICT HEIGHTS MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-14-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Bladensburg Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers & Co Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 16 '58

7134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Hyattsville, Cheverly		3 yrs.		15 Hyattsville							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS							
Prince Georges General Hospital				Cheverly, Md. 5013 54th. Ave.							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Jacob				Eurich				June 19 1958			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
male		white				11/11/1878		79		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
		retired		Germany		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Jacob Eurich		Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		216-05-6315		Mrs. Ernestine Garrity		5013 54th. Ave					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteriosclerotic Heart Disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hrs. 5 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan. 4, 1952, to June 19, 1958, that I last saw the deceased alive on June 19, 1958, and that death occurred at 12:20 P.M. from the causes and on the date stated above											
ACTUAL SIGNATURE Charles C. Hageage		M.D. 3308 Perry St. Mt. Rainier, Md. 6/19/58									
PHYSICIAN'S NAME (Type) Dr. Charles Hageage											
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 6-23-1958		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Lillian Funnell Inc. 7401 Belair Rd.				DATE JUN 24 '58		W. H. Leach					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. OCCASION OF DEATH [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF REGISTRAR [Illegible]		12. SIGNATURE OF WITNESSES [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF NEXT OF KIN [Illegible]		15. SIGNATURE OF BURIAL OFFICER [Illegible]	
16. SIGNATURE OF CHURCH OFFICER [Illegible]		17. SIGNATURE OF FUNERAL HOME [Illegible]		18. SIGNATURE OF CEMETERY [Illegible]	
19. SIGNATURE OF HEALTH OFFICER [Illegible]		20. SIGNATURE OF COUNTY CLERK [Illegible]		21. SIGNATURE OF STATE CLERK [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF NEXT OF KIN [Illegible]		24. SIGNATURE OF BURIAL OFFICER [Illegible]	
25. SIGNATURE OF CHURCH OFFICER [Illegible]		26. SIGNATURE OF FUNERAL HOME [Illegible]		27. SIGNATURE OF CEMETERY [Illegible]	
28. SIGNATURE OF HEALTH OFFICER [Illegible]		29. SIGNATURE OF COUNTY CLERK [Illegible]		30. SIGNATURE OF STATE CLERK [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF NEXT OF KIN [Illegible]		33. SIGNATURE OF BURIAL OFFICER [Illegible]	
34. SIGNATURE OF CHURCH OFFICER [Illegible]		35. SIGNATURE OF FUNERAL HOME [Illegible]		36. SIGNATURE OF CEMETERY [Illegible]	
37. SIGNATURE OF HEALTH OFFICER [Illegible]		38. SIGNATURE OF COUNTY CLERK [Illegible]		39. SIGNATURE OF STATE CLERK [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF NEXT OF KIN [Illegible]		42. SIGNATURE OF BURIAL OFFICER [Illegible]	
43. SIGNATURE OF CHURCH OFFICER [Illegible]		44. SIGNATURE OF FUNERAL HOME [Illegible]		45. SIGNATURE OF CEMETERY [Illegible]	
46. SIGNATURE OF HEALTH OFFICER [Illegible]		47. SIGNATURE OF COUNTY CLERK [Illegible]		48. SIGNATURE OF STATE CLERK [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF NEXT OF KIN [Illegible]		51. SIGNATURE OF BURIAL OFFICER [Illegible]	
52. SIGNATURE OF CHURCH OFFICER [Illegible]		53. SIGNATURE OF FUNERAL HOME [Illegible]		54. SIGNATURE OF CEMETERY [Illegible]	
55. SIGNATURE OF HEALTH OFFICER [Illegible]		56. SIGNATURE OF COUNTY CLERK [Illegible]		57. SIGNATURE OF STATE CLERK [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF NEXT OF KIN [Illegible]		60. SIGNATURE OF BURIAL OFFICER [Illegible]	
61. SIGNATURE OF CHURCH OFFICER [Illegible]		62. SIGNATURE OF FUNERAL HOME [Illegible]		63. SIGNATURE OF CEMETERY [Illegible]	
64. SIGNATURE OF HEALTH OFFICER [Illegible]		65. SIGNATURE OF COUNTY CLERK [Illegible]		66. SIGNATURE OF STATE CLERK [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF NEXT OF KIN [Illegible]		69. SIGNATURE OF BURIAL OFFICER [Illegible]	
70. SIGNATURE OF CHURCH OFFICER [Illegible]		71. SIGNATURE OF FUNERAL HOME [Illegible]		72. SIGNATURE OF CEMETERY [Illegible]	
73. SIGNATURE OF HEALTH OFFICER [Illegible]		74. SIGNATURE OF COUNTY CLERK [Illegible]		75. SIGNATURE OF STATE CLERK [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF NEXT OF KIN [Illegible]		78. SIGNATURE OF BURIAL OFFICER [Illegible]	
79. SIGNATURE OF CHURCH OFFICER [Illegible]		80. SIGNATURE OF FUNERAL HOME [Illegible]		81. SIGNATURE OF CEMETERY [Illegible]	
82. SIGNATURE OF HEALTH OFFICER [Illegible]		83. SIGNATURE OF COUNTY CLERK [Illegible]		84. SIGNATURE OF STATE CLERK [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF NEXT OF KIN [Illegible]		87. SIGNATURE OF BURIAL OFFICER [Illegible]	
88. SIGNATURE OF CHURCH OFFICER [Illegible]		89. SIGNATURE OF FUNERAL HOME [Illegible]		90. SIGNATURE OF CEMETERY [Illegible]	
91. SIGNATURE OF HEALTH OFFICER [Illegible]		92. SIGNATURE OF COUNTY CLERK [Illegible]		93. SIGNATURE OF STATE CLERK [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF NEXT OF KIN [Illegible]		96. SIGNATURE OF BURIAL OFFICER [Illegible]	
97. SIGNATURE OF CHURCH OFFICER [Illegible]		98. SIGNATURE OF FUNERAL HOME [Illegible]		99. SIGNATURE OF CEMETERY [Illegible]	
100. SIGNATURE OF HEALTH OFFICER [Illegible]		101. SIGNATURE OF COUNTY CLERK [Illegible]		102. SIGNATURE OF STATE CLERK [Illegible]	

7135

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 7604 Finns Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Louise Finn		4. DATE OF DEATH Month Day Year June 18 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-87
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Federal Government Washington, D.C.		10b. KIND OF BUSINESS OR INDUSTRY U. S. A.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Hannan		14. MOTHER'S MAIDEN NAME Ellen Drew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mary C. Eversole		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Thrombosis DUE TO (b) Nephrosclerosis - Diabetic DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 2 days 7 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTESTINAL OBSTRUCTION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1957 to June 1958 , that I last saw the deceased alive on 18 Jun 1958 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney M.D.		ADDRESS (Street, city or town, state) 4814-71st Ave.	
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY MD.		DATE SIGNED 18 JUN 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State) Washington, D.C.		22e. REC'D BY REGISTRAR JUN 20 58	
23. FUNERAL DIRECTOR'S SIGNATURE Malloy's Funeral Home Inc.		23b. REGISTRAR'S SIGNATURE W. E. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

7136

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 10 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 W. Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6218 20th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patricia Marie				4. DATE OF DEATH Month June Day 17 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-58		9. AGE (In years last birthday) yrs. 10	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Raymond				14. MOTHER'S MAIDEN NAME Ruth Darrelle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Cheverly Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage in right hemisphere 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Placental dysfunction DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1958 , to June 17, 1958 that I last saw the deceased alive on June 17, 1958 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				ADDRESS (Street, city or town, state) College Park, Md DATE SIGNED			
PHYSICIAN'S NAME (Type) Thomas A. Christensen M.D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 6/19/1958		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JUN 23 '58 24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348

11/11/19

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, See: Birth Cert. et

07138

7137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md c. LENGTH OF STAY IN 1b 1 Monthe/ d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ... Hall, Md. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Roger Lee Galford			4. DATE OF DEATH Month Day Year June 11 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1958		9. AGE (In years last birthday) yrs. 1 Months 2 Days 2 Hours 1 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland			
13. FATHER'S NAME Merritt Galford			14. MOTHER'S MAIDEN NAME Agnes Carpenter Hall, Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mother Hall Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X DUE TO Pneumonia meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) meningitis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 340.3					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month 19 Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)		
21. I certify that I attended the deceased from May 9 , 19 58 , to June 11 , 19 58 , that I last saw the deceased alive on June 11 , 19 58 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bertha Van Gilder		ADDRESS (Street, city or town, state) 3001 Cheverly Ave., Cheverly, Md.		DATE SIGNED June 13			
PHYSICIAN'S NAME (Type) Bertha Van Gilder, M.D.		3001 Cheverly Ave., Cheverly Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6/12/58	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penr, Jr., Administrator.		ADDRESS 3001 Cheverly Ave., Cheverly, Md.		24a. REC'D BY REGISTRAR JUN 18 '58	24b. REGISTRAR'S SIGNATURE W. J. ...		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 17 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Largo Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Largo Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin Middle Elbert Last Gardner				4. DATE OF DEATH Month June Day 17 , 19 58 .			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Produce & Live-Stock		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest Gardner				14. MOTHER'S MAIDEN NAME Cora Needle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Martin E. Gardner, Jr. - Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 976x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound of head DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with star gun					
20c. TIME OF INJURY Month, Day, Year 3rd 6-17-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/58		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-				24a. REC'D BY REGISTRAR Maryland.		24b. REGISTRAR'S SIGNATURE DATE JUN 20 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male	
AGE 45 years		RACE White	
PLACE OF BIRTH Boston, Mass.		DATE OF BIRTH Jan. 1, 1900	
OCCUPATION Clerk		MARITAL STATUS Single	
STREET ADDRESS 123 Main St.		CITY Boston	
STATE Mass.		COUNTY Suffolk	
CAUSE OF DEATH Heart disease			
MANNER OF DEATH Natural			
SIGNATURE OF EXAMINER Dr. John Smith			
DATE Jan. 15, 1945			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07140

7138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b 33 4203 53rd ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Bladensburg, Md.	
3. NAME OF DECEASED (Type or print) First William Middle E. Last Gasson		4. DATE OF DEATH Month June Day 29 , Year 58-19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1883
9. AGE (In years and birthday) yrs. 74		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Washington Gas Company		10b. KIND OF BUSINESS OR INDUSTRY Washington D. C.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry J. Gasson		14. MOTHER'S MAIDEN NAME Mary E. Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT William C. De Neane		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease (c) Complete Heart Block		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1946 to June 27, 1958 , that I last saw the deceased alive on June 27, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dayton O Watkins M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 6-29-58	
PHYSICIAN'S NAME (Type) DAYTON O WATKINS		Bladensburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE JUL 2 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07140

7139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY P.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys E. Gervais		4. DATE OF DEATH June 8 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Dawsonville	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Peter J. Stang		14. MOTHER'S MAIDEN NAME Helene A. Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Lorraine E. Babcock		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio-sclerotic Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1949, to June 8, 1958, that I last saw the deceased alive on June 8, 1958, and that death occurred at 4:03 pm, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. C. Hageage		M.D. 3308 Perry St., Mt. Rainier, Md. 6/	
PHYSICIAN'S NAME (Type) C. C. Hageage M.D.		3308 Perry St. Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/58	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Bristol, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley Funeral Home		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS 3200 N. D. Ave. Mt. Rainier, Md.		DATE JUN 11 1958	

7114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Maryland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Glick				4. DATE OF DEATH Month June Day 11 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Daniel F. McMullen				14. MOTHER'S MAIDEN NAME Anna McNamee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. John H. Glick 308 Washington St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 10, 1958 , to June 16, 1958 , that I last saw the deceased alive on June 10, 1958 , and that death occurred at 5:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William T. Saccardi M.D.							
PHYSICIAN'S NAME (Type) WILLIAM T. SACCARDI 1150 Conn. Ave Wash DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7140

CERTIFICATE OF DEATH

07143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 Bladensburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>GRADY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1887</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor R.R. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Orange Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Grady</u>		14. MOTHER'S MAIDEN NAME <u>Helen Audrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Amy K. Grady</u>		Address <u>5212 Tilden Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 31, 1958</u> , to <u>JUNE 6, 1958</u> , that I last saw the deceased alive on <u>JUNE 6, 1958</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Rosson</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd, Bladensburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WASH D.C.</u>		DATE SIGNED <u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Menwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D C</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>		ADDRESS <u>4812 Hyattsville Wash D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE FOR SIGNATURE

NAME OF DECEASED
JAMES EARL RAY
AGE 35
SEX MALE
RACE WHITE
BIRTH DATE 12-5-28
BIRTH PLACE MOBILE, ALA.

DATE OF DEATH 4-4-68
PLACE OF DEATH MOBILE, ALA.
CAUSE OF DEATH
CORONARY THROMBOSIS
MURDER

DECEASED'S RESIDENCE
1111 1/2 AVENUE
MOBILE, ALA. 36682

DECEASED'S OCCUPATION
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE

DECEASED'S MARITAL STATUS
MARRIED
NAME OF SPOUSE
JANET A. RAY

DECEASED'S RELIGION
METHODIST
NAME OF MINISTER
DR. J. L. RAY

DECEASED'S SIGNATURE
JAMES EARL RAY
DATE 4-4-68

7197

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaumont Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaumont Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2219 Beaumont Heights</u>				d. STREET ADDRESS <u>2219 Beaumont Heights</u>			
3. NAME OF DECEASED (Type or print) <u>James Jay Gregory</u>				4. DATE OF DEATH <u>June 16 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1946</u>	
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>Columbia</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>William L Gregory</u>				14. MOTHER'S MAIDEN NAME <u>Mildred G. Holmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>William L Gregory, Sane</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> <u>9250</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Being trapped in a cedar chest</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in a cedar chest</u>			
20c. TIME OF INJURY Month, Day, Year <u>June 16 1958</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Beaumont Heights</u> (County) <u>D.C.</u> (State) <u>Pa.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 16, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>6/18/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>				22d. LOCATION (City, town, or county) <u>Bladensburg, Md.</u> (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>				ADDRESS <u>517 11th St SE</u>			
24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED
Name: John Doe
Age: 45 Sex: M
Race: W Date of Birth: 10-15-1910
Place of Birth: MD
Usual Residence: 123 Main St, Baltimore, MD
Cause of Death: Heart Disease
Manner of Death: Natural
Signature of Examiner: [Signature]
Date: 10-20-1955

INTERVIEW WITH NEXT OF KIN
Name: John Doe
Address: 123 Main St, Baltimore, MD
Occupation: Teacher
Relationship to Deceased: Spouse
Signature: [Signature]
Date: 10-20-1955

INTERVIEW WITH PHYSICIAN
Name: Dr. J. Smith
Address: 456 Oak St, Baltimore, MD
Occupation: Physician
Signature: [Signature]
Date: 10-20-1955

INTERVIEW WITH CORONER
Name: Mr. J. Brown
Address: 789 Pine St, Baltimore, MD
Occupation: Coroner
Signature: [Signature]
Date: 10-20-1955

INTERVIEW WITH POLICE
Name: Officer J. Green
Address: 101 Elm St, Baltimore, MD
Occupation: Police Officer
Signature: [Signature]
Date: 10-20-1955

INTERVIEW WITH NEIGHBORS
Name: Mr. J. White
Address: 202 Maple St, Baltimore, MD
Occupation: Neighbor
Signature: [Signature]
Date: 10-20-1955

INTERVIEW WITH OTHERS
Name: Mr. J. Black
Address: 303 Cedar St, Baltimore, MD
Occupation: Neighbor
Signature: [Signature]
Date: 10-20-1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7198

CERTIFICATE OF DEATH

Reg. Dist. No. 07145

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. LENGTH OF STAY IN 1b <u>2 months and 17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>634 Que St., N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Grimes</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/22/22</u>	9. AGE (In years last birthday) <u>35</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Veterans Administration</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Paul Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fitzhugh Grimes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1942 - 1943 579-14-7564</u>		17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Post-operative hemorrhage</u> <u>002X</u> DUE TO <u>Right upper lobectomy and removal of superior segment of right lower lobe.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6/3/58</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>58</u> , to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/5/58</u> , and that death occurred at <u>2:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Wein</u>		M.D.		ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>		DATE SIGNED <u>6/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Glenn Dale, Md.</u>							
22a. DATE OF REMOVAL (Specify)	22b. DATE THEREOF <u>6/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Wein</u>				ADDRESS <u>11432 1st St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Wein</u>			

CERTIFICATE OF DEATH

1153

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]	
DATE OF DEATH [Date]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]		PLACE OF BURIAL [Place]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF JUDGE [Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 1153

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherbury</u>		c. LENGTH OF STAY IN 1b <u>Headonamel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>			d. STREET ADDRESS <u>Upper Marlboro</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Sylvester Harrison</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept 27, 1904</u>		9. AGE (in years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. - G</u>		13. FATHER'S NAME <u>Norman Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-168753</u>		17. INFORMANT <u>Edna Harrison, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Hemorrhage and shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of stomach</u> (c) <u> </u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 20, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.23.58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Upper Marlboro, Maryland</u>		22e. (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		ADDRESS <u>1820 9th St., N.W.</u> <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>					

MEDICAL CERTIFICATION

2

2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
KENT AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED: John Doe
AGE: 45 SEX: M
RESIDENCE: 123 Main St, Baltimore, Md
DATE OF DEATH: Jan 15, 1912
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
DISEASE OR INJURY: Myocardial Infarction
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: [Signature]
DATE: Jan 16, 1912
LOCAL HEALTH OFFICER: [Signature]
COUNTY CLERK: [Signature]
CITY CLERK: [Signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pi. Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Vista</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>			d. STREET ADDRESS <u>Defense Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dahm Wayne Hebron</u>	4. DATE OF DEATH <u>June - 10 - 1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-58</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>Dahm W. Hebron</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>Thebma Chase</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thebma Chase; same address.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John W. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 10-1958</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-20-58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) <u>Arlington Va</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry I. Washington</u>		ADDRESS <u>467 N. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

TWO VVVVVXVV



7143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Rt #1 Box 412		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alberta Middle Mae Last Herberson				4. DATE OF DEATH Month June Day 22 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1910	
9. AGE (In years lost birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Cornelius Martin Frye				14. MOTHER'S MAIDEN NAME Idella Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of breast DUE TO (c) 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 18, 1958 , to June 22, 1958 , that I last saw the deceased alive on June 22, 1958 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 150 Washington Blvd. DATE SIGNED June 22, 1958							
ACTUAL SIGNATURE Oscar B. Camp, M.D.				PHYSICIAN'S NAME (Type) OSCAR B. CAMP, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Trinity Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Witherspoon ADDRESS Laurel, Md.				24a. REC'D BY REGISTRAR DATE JUN 26 '58		24b. REGISTRAR'S SIGNATURE W. H. Witherspoon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF DEATH Jan 15 1925	
5. PLACE OF DEATH Home		6. OCCUPATION Teacher		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. PLACE OF BIRTH Baltimore		10. DATE OF BIRTH Jan 1 1880		11. SEX OF BIRTH Male		12. COLOR White	
13. NAME OF FATHER John Doe		14. NAME OF MOTHER John Doe		15. NAME OF SPOUSE John Doe		16. NAME OF CHILDREN John Doe	
17. NAME OF PHYSICIAN John Doe		18. NAME OF NURSE John Doe		19. NAME OF BURIAL PLACE John Doe		20. NAME OF FUNERAL HOME John Doe	
21. NAME OF MINISTER John Doe		22. NAME OF CHURCH John Doe		23. NAME OF CEMETERY John Doe		24. NAME OF INTERMENT John Doe	
25. NAME OF CORPSE John Doe		26. NAME OF CLOTHES John Doe		27. NAME OF SHIRT John Doe		28. NAME OF TIE John Doe	
29. NAME OF COAT John Doe		30. NAME OF PANTS John Doe		31. NAME OF SHOES John Doe		32. NAME OF HAT John Doe	
33. NAME OF GLOVES John Doe		34. NAME OF SOCKS John Doe		35. NAME OF UNDERWEAR John Doe		36. NAME OF BEDDING John Doe	
37. NAME OF PILLOW John Doe		38. NAME OF BLANKET John Doe		39. NAME OF CURTAINS John Doe		40. NAME OF FURNITURE John Doe	
41. NAME OF LIGHTS John Doe		42. NAME OF HEAT John Doe		43. NAME OF COOKING John Doe		44. NAME OF CLEANING John Doe	
45. NAME OF WASHING John Doe		46. NAME OF DRESSING John Doe		47. NAME OF EATING John Doe		48. NAME OF DRINKING John Doe	
49. NAME OF SLEEPING John Doe		50. NAME OF WALKING John Doe		51. NAME OF RUNNING John Doe		52. NAME OF SWIMMING John Doe	
53. NAME OF FLYING John Doe		54. NAME OF DRIVING John Doe		55. NAME OF RIDING John Doe		56. NAME OF BOATING John Doe	
57. NAME OF FISHING John Doe		58. NAME OF HUNTING John Doe		59. NAME OF GARDENING John Doe		60. NAME OF WORKING John Doe	
61. NAME OF PLAYING John Doe		62. NAME OF STUDYING John Doe		63. NAME OF TEACHING John Doe		64. NAME OF LEARNING John Doe	
65. NAME OF KNOWING John Doe		66. NAME OF UNDERSTANDING John Doe		67. NAME OF FEELING John Doe		68. NAME OF THINKING John Doe	
69. NAME OF BELIEVING John Doe		70. NAME OF TRUSTING John Doe		71. NAME OF HOPEING John Doe		72. NAME OF WAITING John Doe	
73. NAME OF WATCHING John Doe		74. NAME OF LISTENING John Doe		75. NAME OF SMELLING John Doe		76. NAME OF TASTING John Doe	
77. NAME OF FEELING John Doe		78. NAME OF TOUCHING John Doe		79. NAME OF MOVING John Doe		80. NAME OF STAYING John Doe	
81. NAME OF GOING John Doe		82. NAME OF COMING John Doe		83. NAME OF LEAVING John Doe		84. NAME OF RETURNING John Doe	
85. NAME OF ENTERING John Doe		86. NAME OF EXITING John Doe		87. NAME OF PASSING John Doe		88. NAME OF CROSSING John Doe	
89. NAME OF UNDERPASSING John Doe		90. NAME OF OVERPASSING John Doe		91. NAME OF THROUGH John Doe		92. NAME OF ACROSS John Doe	
93. NAME OF WITHIN John Doe		94. NAME OF WITHOUT John Doe		95. NAME OF AMONG John Doe		96. NAME OF BETWEEN John Doe	
97. NAME OF AGAINST John Doe		98. NAME OF FOR John Doe		99. NAME OF FROM John Doe		100. NAME OF TO John Doe	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. OCCUPATION
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. DATE OF BIRTH
11. SEX OF BIRTH
12. COLOR
13. NAME OF FATHER
14. NAME OF MOTHER
15. NAME OF SPOUSE
16. NAME OF CHILDREN
17. NAME OF PHYSICIAN
18. NAME OF NURSE
19. NAME OF BURIAL PLACE
20. NAME OF FUNERAL HOME
21. NAME OF MINISTER
22. NAME OF CHURCH
23. NAME OF CEMETERY
24. NAME OF INTERMENT
25. NAME OF CORPSE
26. NAME OF CLOTHES
27. NAME OF SHIRT
28. NAME OF TIE
29. NAME OF COAT
30. NAME OF PANTS
31. NAME OF SHOES
32. NAME OF HAT
33. NAME OF GLOVES
34. NAME OF SOCKS
35. NAME OF UNDERWEAR
36. NAME OF BEDDING
37. NAME OF PILLOW
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39. NAME OF CURTAINS
40. NAME OF FURNITURE
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99. NAME OF FROM
100. NAME OF TO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149

7199

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b 45 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6509 Central Ave				d. STREET ADDRESS 16509 Central Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LILLIE MAE HERN				4. DATE OF DEATH June 15 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 15 1881	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House Wfr				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Wash DC	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph W. Lunnell				14. MOTHER'S MAIDEN NAME Josephine Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Margaret McLaughlin 47-68th Ave Seat Pleasant				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION DUE TO (b) CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 11, 1958, to June 15, 1958, that I last saw the deceased alive on June 14, 1958, and that death occurred at 1:24 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE William Brainin M.D. 6124 Central Ave ADDRESS (Street, city or town, state) DATE SIGNED 6/15/58 PHYSICIAN'S NAME (Type) WM BRAININ Capitol Hygiene							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-17-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lill Funeral Home - DC ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1139

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Jan 15 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CITY <i>Baltimore</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>PREVAILING DISEASE <i>Coronary Artery Disease</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>DATE OF BIRTH <i>Jan 1 1873</i></p>		<p>PLACE OF BIRTH <i>Germany</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>DATE OF MARRIAGE <i>Jan 1 1900</i></p>		<p>NAME OF SPOUSE <i>Jane Doe</i></p>		<p>DATE OF MARRIAGE <i>Jan 1 1900</i></p>		<p>NAME OF SPOUSE <i>John Doe</i></p>	
<p>DATE OF DEATH <i>Jan 15 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CITY <i>Baltimore</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>PREVAILING DISEASE <i>Coronary Artery Disease</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>DATE OF BIRTH <i>Jan 1 1873</i></p>		<p>PLACE OF BIRTH <i>Germany</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>DATE OF MARRIAGE <i>Jan 1 1900</i></p>		<p>NAME OF SPOUSE <i>Jane Doe</i></p>		<p>DATE OF MARRIAGE <i>Jan 1 1900</i></p>		<p>NAME OF SPOUSE <i>John Doe</i></p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150

**FOR STATE
HEALTH DEPT.**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire		c. LENGTH OF STAY IN lb 6 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7410 Nyack Place		d. STREET ADDRESS 7410 Nyack Place	
3. NAME OF DECEASED (Type or print) Clayton John Hollen		4. DATE OF DEATH Month June Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1915
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Vending machines	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ellis Hollen		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 171-07-5036	
17. INFORMANT Mrs Dorothy Hollen, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED June 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 317 PA. AVE., S. E.		24a. REC'D BY REGISTRAR DATE JUN 9 1958	
24b. REGISTRAR'S SIGNATURE W. E. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John J. Hagan</u></p>		<p>2. Date of Death: <u>June 2, 1958</u></p>	
<p>3. Place of Death: <u>Home</u></p>		<p>4. Address: <u>1111 York Place</u></p>	
<p>5. City: <u>Baltimore</u></p>		<p>6. State: <u>Md.</u></p>	
<p>7. Age: <u>68</u></p>		<p>8. Sex: <u>Male</u></p>	
<p>9. Race: <u>White</u></p>		<p>10. Occupation: <u>None</u></p>	
<p>11. Cause of Death: <u>Myocardial Infarction</u></p>		<p>12. Manner of Death: <u>Natural</u></p>	
<p>13. Date of Autopsy: <u>June 3, 1958</u></p>		<p>14. Signature of Examiner: <u>James J. Hagan</u></p>	
<p>15. Signature of Physician: <u>James J. Hagan</u></p>		<p>16. Signature of Coroner: <u>James J. Hagan</u></p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07151

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baden</u>	
c. LENGTH OF STAY IN 1b <u>40 years</u>		d. STREET ADDRESS <u>Home Head Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home Head Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edgar Hyde</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1888</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. - R</u>	
13. FATHER'S NAME <u>George Hyde</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>0088000</u>	
17. INFORMANT <u>Elizabeth L. Baden</u>		Address <u>Brandywine Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound of chest</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 6, 1958</u> Hour <u>2</u> a. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Baden P. S. Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baden, Maryland.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>Jun 20 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5301 Greenway Ave.				d. STREET ADDRESS 15301 Greenway Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNIE Middle LEE Last JOHNSON				4. DATE OF DEATH Month JUNE Day 7 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 23, 1878	
				9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Pearson				14. MOTHER'S MAIDEN NAME Etta Pearson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. Yes			
17. INFORMANT John D. Meade				Address 5301 Greenway Ave. Riverdale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease? DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 hr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 6, 1958 , to JUNE 7, 1958 , that I last saw the deceased alive on JUNE 7, 1958 , and that death occurred at 10:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Ross				ADDRESS (Street, city or town, state) 5304 ANNAPOLIS RD.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON				BLADENBURGH, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Shutland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc.				ADDRESS 517-11th St. A. E.		24a. REC'D BY REGISTRAR JUN 10 58	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PRINCE GEORGE'S		RIVERBROOK	
MARRYLAND		RIVERBROOK	
3301 Cassinway Ave			
Annie Lee Johnson		June 11, 1908	
Female		White	
Mar 23, 1878		44	
Arteriosclerotic Cardiovascular Disease ?			
Cerebrovascular Thrombosis			
June 6, 1908			
June 7, 1908			
June 8, 1908			
June 9, 1908			
June 10, 1908			
June 11, 1908			
June 12, 1908			
June 13, 1908			
June 14, 1908			
June 15, 1908			
June 16, 1908			
June 17, 1908			
June 18, 1908			
June 19, 1908			
June 20, 1908			
June 21, 1908			
June 22, 1908			
June 23, 1908			
June 24, 1908			
June 25, 1908			
June 26, 1908			
June 27, 1908			
June 28, 1908			
June 29, 1908			
June 30, 1908			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7145

CERTIFICATE OF DEATH

07154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Johnson Last Johnson		4. DATE OF DEATH Month June Day 5 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Nov. 1879
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Clara Brown 151 Church Road, Mitchellville, Md.	
17. INFORMANT Clara Brown 151 Church Road, Mitchellville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart of Arteriosclerosis 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 157x DUE TO (c) 157x		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1958 to June 5, 1958 , that I last saw the deceased alive on June 5, 1958 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 3503 Cherry St. Mt. Rainier Md 6/6/58	
ACTUAL SIGNATURE Norman Corneau		M.D. Norman Corneau, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery		22d. LOCATION (City, town, or county) (State) Woodmore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Stewart		ADDRESS 30 H Street, N.E. D.C.	
24a. REC'D BY REGISTRAR June 9 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 1

NAME OF DECEASED JOHN J. SMITH SEX M AGE 45 RACE W BIRTH 1900 PLACE OF BIRTH MD

DATE OF DEATH 1945 PLACE OF DEATH HOME CAUSE OF DEATH HEART DISEASE

DECEASED'S RESIDENCE 1234 E. BALTIMORE ST. CITY BALTIMORE STATE MD

DECEASED'S OCCUPATION CLERK EMPLOYER'S NAME ABC COMPANY

DECEASED'S MARITAL STATUS MARRIED SPOUSE'S NAME JANE D. SMITH

DECEASED'S EDUCATION HIGH SCHOOL GRADE 12

DECEASED'S RELIGION CATHOLIC MINISTER FR. J. J. SMITH

DECEASED'S PREVIOUS ILLNESS HEART DISEASE DATE OF ONSET 1940

DECEASED'S PREVIOUS SURGERY NONE DATE OF SURGERY NONE

DECEASED'S PREVIOUS TRAUMA NONE DATE OF TRAUMA NONE

DECEASED'S PREVIOUS DRUGS NONE DATE OF DRUGS NONE

DECEASED'S PREVIOUS ALCOHOL NONE DATE OF ALCOHOL NONE

DECEASED'S PREVIOUS TOBACCO NONE DATE OF TOBACCO NONE

DECEASED'S PREVIOUS OTHER NONE DATE OF OTHER NONE

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7202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges!</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges!</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Rt. #4.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Pauly</u> Last <u>Kelly</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> , Year <u>1958.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Albany, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Casper Pauly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mueller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>John Lewis Kelly-</u>		Address <u>Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Conjunctive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 2, 1958</u> to <u>June 30, 1958</u> , that I last saw the deceased alive on <u>June 29, 1958</u> , and that death occurred at <u>8:05 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James G. Sasscer</u> M.D.		ADDRESS (Street, city or town, state) <u>Upper Marlboro, Md.</u> DATE SIGNED <u>7-1-58</u>	
PHYSICIAN'S NAME (Type) <u>James G. Sasscer, M. D.</u>		<u>Upper Marlboro, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Catholic Cem:</u>		22d. LOCATION (City, town, or county) (State) <u>Albany, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7303

Reg. No. 114

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>DATE OF DEATH JANUARY 15, 1934</p>	
<p>PLACE OF DEATH BALTIMORE, MARYLAND</p>		<p>AGE 68</p>	
<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>BIRTH DATE MAY 1, 1866</p>		<p>BIRTH PLACE BALTIMORE, MARYLAND</p>	
<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION LABORER</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE CORONARY THROMBOSIS</p>	
<p>INTERVIEWED BY J. H. HARRIS</p>		<p>DATE OF INTERVIEW JANUARY 15, 1934</p>	
<p>SIGNATURE OF DECEASED JAMES H. HARRIS</p>		<p>SIGNATURE OF WITNESS J. H. HARRIS</p>	
<p>DATE OF SIGNATURE JANUARY 15, 1934</p>		<p>DATE OF SIGNATURE JANUARY 15, 1934</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 230 6-17-58 et

07155

7146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6200 Pontiac St., Berwyn Heights, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah		First Middle Last Kielsohn		4. DATE OF DEATH June 8, 1958		Month Day Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/90	9. AGE (In years lost (in day) yrs. 68)	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH FINE				14. MOTHER'S MAIDEN NAME RACHEL BERGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT William Kielsohn, 183-42-ARCADIA AVE STAIRANS-NY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute Cardiac Failure DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) — DUE TO — (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 days 10-12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Hemorrhage						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May - 5, 1957 to 6/8, 1958 , that I last saw the deceased alive on 6-7, 1958 , and that death occurred at 9:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) — DATE SIGNED 6-8-58							
ACTUAL SIGNATURE William M. Eisner M.D.				DATE SIGNED 6-8-58			
PHYSICIAN'S NAME (Type) William M. Eisner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) —		22b. DATE THEREOF 6-10-58		22c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEM.		22d. LOCATION (City, town, or county) (State) STATEN ISLAND NY	
23. FUNERAL DIRECTOR'S SIGNATURE B. Langansky & Son				ADDRESS 3501-145TH AVE		24a. REC'D BY REGISTRAR JUN 10 '58	
						24b. REGISTRAR'S SIGNATURE W. K. K.	

CERTIFICATE OF DEATH

MD-204 (Rev. 1-64)

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35	
4. RACE W		5. DATE OF BIRTH 12/5/28		6. PLACE OF BIRTH MOBILE, ALA.	
7. MARITAL STATUS M		8. OCCUPATION CONGRESSMAN		9. CAUSE OF DEATH HEART DISEASE	
10. DATE OF DEATH 4/4/68		11. PLACE OF DEATH MEMPHIS, TENN.		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF CLERK [Signature]		15. SIGNATURE OF WITNESS [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF BURIAL OFFICIAL [Signature]	
19. SIGNATURE OF FUNERAL HOME [Signature]		20. SIGNATURE OF CHURCH OFFICIAL [Signature]		21. SIGNATURE OF CEMETERY OFFICIAL [Signature]	
22. SIGNATURE OF MARRIAGE OFFICIAL [Signature]		23. SIGNATURE OF VITALS OFFICIAL [Signature]		24. SIGNATURE OF HEALTH OFFICIAL [Signature]	
25. SIGNATURE OF DEATH OFFICIAL [Signature]		26. SIGNATURE OF DEATH OFFICIAL [Signature]		27. SIGNATURE OF DEATH OFFICIAL [Signature]	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07156

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>38</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>			d. STREET ADDRESS <u>6303-Inwood Street</u>		
3. NAME OF DECEASED (Type or print) <u>Margaret Dick</u> <u>King</u> First Middle Last			4. DATE OF DEATH <u>June 4- 1958</u> Month Day Year		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William W. Stoddard</u>		
14. MOTHER'S MAIDEN NAME <u>Phoebe Anna Dick</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Octavia Rouzeau; same address.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D. EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>			22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flushing</u>
22d. LOCATION (City, town, or county) <u>New York</u> (State)			23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland.</u>		
24a. REC'D BY REGISTRAR <u>JUN 6 '58</u>			24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF DEATH: _____

5. PLACE OF DEATH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF MEDICAL EXAMINER: _____

10. SIGNATURE OF CORONER: _____

11. SIGNATURE OF WITNESS: _____

12. SIGNATURE OF WITNESS: _____

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100. SIGNATURE OF WITNESS: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File G230 6-16-58 et

7115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6613 24th Ave. (Daughter's home)</u>				d. STREET ADDRESS <u>1 6613 24th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>MARIE</u> Last <u>KHOPPMAN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 23-1878</u>	
9. AGE (In years (last birthday) yrs.) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Neal</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Full name) <u>Mrs Hennings</u>		Address <u>6613 24th Ave Hyattsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Arteriosclerotic Hypertension</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Arteriosclerosis & Senility</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Pittsburgh</u>				20g. (County) <u>P.G.</u>		20h. (State) <u>Penn.</u>	
21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>5:40</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. X. Courtney</u>				ADDRESS (Street, city or town, state) <u>5601-42nd St Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>J. X. COURTNEY M.D.</u>				DATE SIGNED <u>June 6/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburgh Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Lee & Sons</u>				ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. ...</u>			

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX MALE	
3. DATE OF BIRTH 1910-01-15		4. PLACE OF BIRTH NEW YORK, N.Y.	
5. DATE OF DEATH 1965-03-10		6. PLACE OF DEATH HOME	
7. TIME OF DEATH 10:30 A.M.		8. CAUSE OF DEATH HEART DISEASE	
9. MANNER OF DEATH NATURAL		10. MEDICAL HISTORY None	
11. OCCUPATION None		12. EDUCATION None	
13. MARITAL STATUS None		14. RELIGION None	
15. PRESENT ADDRESS None		16. PREVIOUS ADDRESSES None	
17. SIGNATURE OF DECEASED None		18. SIGNATURE OF WITNESS None	
19. SIGNATURE OF PHYSICIAN None		20. SIGNATURE OF CORONER None	
21. SIGNATURE OF REGISTRAR None		22. SIGNATURE OF CLERK None	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.

18-10000-10-1-65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7148

CERTIFICATE OF DEATH

07158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Knically				4. DATE OF DEATH Month June Day 16 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-58		9. AGE (In years last birthday) yrs. 6 10		IF UNDER 1 YEAR Months 6 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Robert Knically Unknown			
14. MOTHER'S MAIDEN NAME Frances Knically				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT mother - as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 16, 1958 , to June 16, 1958 , that I last saw the deceased alive on June 16, 1958 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamlet St, Hyattsville, Md			
PHYSICIAN'S NAME (Type) John W. Perkins				DATE SIGNED 6/18/58			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION Prince George's General Hosp., Cheverly, Maryland				22b. DATE THEREOF 6/23/58			
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp., Cheverly, Maryland				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				ADDRESS Cheverly, Maryland			
24a. REC'D BY REGISTRAR W. H. Beach				24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

1968

Reg. No. 10

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Race: [Illegible]

4. Date of Birth: [Illegible]

5. Date of Death: [Illegible]

6. Place of Birth: [Illegible]

7. Usual Residence: [Illegible]

8. Cause of Death: [Illegible]

9. Manner of Death: [Illegible]

10. Signature of Physician: [Illegible]

11. Signature of Registrar: [Illegible]

12. Date of Registration: [Illegible]

WILLIAM BOND

7203 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland md. Washington 23 DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4815 Suitland Rd</u>				d. STREET ADDRESS <u>4815 Suitland Rd SE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George Wesley Lawrence</u>				4. DATE OF DEATH <u>June 23 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>US white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7 1900</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Sara Francis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>226016587</u>		17. INFORMANT <u>Wife</u> <u>Maryle Lawrence</u> <u>Washington 23 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon with</u> DUE TO (c) <u>metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>2.4 HOURS</u> <u>11 Mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>natural causes</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 1</u> , 1957, to <u>June 23</u> , 1958, that I last saw the deceased alive on <u>June 23</u> , 1958, and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington 28 DC</u> DATE SIGNED <u>June 25 1958</u>							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u> <u>Washington 28 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661-Good Hope Rd SE Wash. DC</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7204

CERTIFICATE OF DEATH

Reg. Dist. No.

07160

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr. 8 mos. & 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 920 E. St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Moulton Lawrence				4. DATE OF DEATH Month Day Year 6 11 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/13/1896		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail clerk		10b. KIND OF BUSINESS OR INDUSTRY Advertising Distribution of Washington		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Lawrence				14. MOTHER'S MAIDEN NAME Minnie Moulton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 267-01-4761		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 yrs. & 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema and cor pulmonale						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/12, 1956, to 6/11, 1958, that I last saw the deceased alive on 6/11, 1958, and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 6/11/58 M.D. Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Meyer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Chamber Co.				ADDRESS 1400 Chapin St. N.W.		24a. REC'D BY REGISTRAR DATE JUN 17 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

7205

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek				c. LENGTH OF STAY IN 1b 8 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Accokeek, Maryland				d. STREET ADDRESS Accokeek, Maryland			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRIEDRICH Middle G. Last LINDNER				4. DATE OF DEATH Month JUNE Day 4th. Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12- 1902		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johann M. Lindner				14. MOTHER'S MAIDEN NAME Rosina Lindner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Emma R. Lindner Accokeek, Md. (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compensated Myocardial Infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 to June 3 , 19 58 that I last saw the deceased alive on June 3 , 19 58 , and that death occurred at 5 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. H. Yorkhoff				ADDRESS (Street, city or town, state) 3122 Nichols Ave SE			
PHYSICIAN'S NAME (Type) F. H. Yorkhoff M.D.				DATE SIGNED Wash D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Sommers Brothers				ADDRESS 1661- Good Hope Rd. SE		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
				24b. REGISTRAR'S SIGNATURE Al. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		c. LENGTH OF STAY IN 1b 1 Day		d. STREET ADDRESS 2605 Lackawanna St	
3. NAME OF DECEASED (Type or print) Walter Edward Lintelman		4. DATE OF DEATH Month June Day 1 Year 19 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-98	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Western Elec.		11. BIRTHPLACE (State or foreign country) Wilkinsburg Penna.	
13. FATHER'S NAME Edward Lintelman		14. MOTHER'S MAIDEN NAME Anna Niemeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 169-01-5635		17. INFORMANT Richard B. Stewart Address 2605 Lackawanna St W. Hyattsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perf. Antenna gastric ulcer DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6-1 , 19 58 , to 6-2 , 19 58 , that I last saw the deceased alive on 6-2 , 19 58 , and that death occurred at 12:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 6-2-58 ACTUAL SIGNATURE Dr. Aaron Deitz M.D. PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, or other disposal of body Removal		22b. DATE THEREOF 6-2-'58		22c. NAME OF CEMETERY OR CREMATORY Unknown	
22d. LOCATION (City, town, or county) Pittsburgh		22e. (State) Penna		22f. (Country)	
23. REGISTRAR'S SIGNATURE W. W. Chambers Co		ADDRESS 5801 Cleve. Ave. Riverdale MD.		24a. REC'D BY REGISTRAR JUN 4 '58	
24b. REGISTRAR'S SIGNATURE Archer					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Death		Jan 15 1911	
Place of Death		Home	
Cause of Death		Heart Disease	
Occupation		Teacher	
Residence		123 Main St, Baltimore, Md.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan 16 1911	
Registrar's Office		Baltimore, Md.	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07163

7150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN lb 1 year			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. STREET ADDRESS 11702 Emac Road			
3. NAME OF DECEASED (Type or print) John Joseph Luby, Jr.				4. DATE OF DEATH June 11 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-11-21	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Joseph Luby				14. MOTHER'S MAIDEN NAME Margaret E. Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 577-24-8816		17. INFORMANT Address Margaret E. Robert; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 11, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF June 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		22d. LOCATION (City, town, or county) (State) Switzland Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 254 Carroll St. N.W. D.C.				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Joseph Henry	
Age		37-38-39	
Sex		Male	
Race		White	
Date of Death		11-13-21	
Place of Death		Home	
Cause of Death		Acute congestive heart failure	
Disease		Cardiovascular renal disease	
Occupation		None	
Signature of Physician		John T. Hanney, M.D.	
Signature of Medical Examiner		John T. Hanney, M.D.	
Date		Jan 11, 1922	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07164

7120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>P. Leo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>16107 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH NELSON LUCAS</u>		4. DATE OF DEATH Month Day Year <u>June 19, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-09</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George N. Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Bobac</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mary V. Lucas - mother</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recurrent Coronary insufficiency</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 40 min</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 18, 1958</u> , to <u>June 19, 1958</u> , that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal</u> M.D. <u>9210 Oakville Rd., Silver Spring, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Full Funeral Home - D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE JUN 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Allen</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07165

7151

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md c. LENGTH OF STAY IN 1b 1 Month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. d. STREET ADDRESS 5405 37th Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cornelia MARY XXX Lusby		4. DATE OF DEATH Month June Day 12 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/08
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Worcester, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur A. Girouard		14. MOTHER'S MAIDEN NAME Cornelia Amelotte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William C. Lusby		Address 5405 37 Ave., Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parasomnia & the uterus DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 58 , to June 12 , 19 58 , that I last saw the deceased alive on 6-11 , 19 58 , and that death occurred at 10:30AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 6-12-58 ACTUAL SIGNATURE Aaron Dietz M.D. PHYSICIAN'S NAME (Type) Aaron Dietz M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/14/58	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Silver Spring, Montgomery Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
24b. REGISTRAR'S SIGNATURE W. E. Humphrey			

CERTIFICATE OF DEATH

Form No. 10

Form containing fields for death certificate information, including name, date, and location. The form is oriented horizontally but contains vertical text labels for fields such as 'Name', 'Date', and 'Place of Birth'. The text is mirrored across the page.

CERTIFICATE OF DEATH

07166

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georg's General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie First Middle Last Mackall		4. DATE OF DEATH Month Day Year June 27 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-87
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min. 19 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217300816	
17. INFORMANT Horace Owen, Upper Marlboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical Shock 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mesenteric Thrombosis DUE TO (c) Embolization from Aneurysm of Thoracic Aorta			INTERVAL BETWEEN ONSET AND DEATH 24 hours. 24 hours.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 26 , 19 58 , to June 27 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 5 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd, Upper Marlboro, Md. DATE SIGNED 6-27-58 ACTUAL SIGNATURE David Watkins M.D. Bladesburg, Md. PHYSICIAN'S NAME (Type) David Watkins, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) 6-30-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Rollins		ADDRESS 4339 Hunt Rd, NE	
24a. REC'D BY REGISTRAR Jul 1 '58		24b. REGISTRAR'S SIGNATURE Red Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 1 1/2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1304 Nicholson Street Block		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
3. NAME OF DECEASED (Type or print) George Peter Mantzouris		4. DATE OF DEATH Month June Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1954
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter George Mantzouris		14. MOTHER'S MAIDEN NAME Carolyn Castle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 000-00-0000	
17. INFORMANT Arlington, Va. Thomas Castle; 1605 s. 28th St.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma, multiple and severe (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Body run over by automobile truck.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Body run over by automobile truck.		20c. TIME OF INJURY Month, Day, Year 9.25 a.m. 6-27-58	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Vacant lot	
20f. (City or town) Hyattsville, Pr. Geo. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 27, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cem		22d. LOCATION (City, town, or county) (State) Wash DC	
23. FUNERAL DIRECTOR'S SIGNATURE W.F. Huntman & Son Inc		ADDRESS 5752 Ave	
24a. REC'D BY REGISTRAR JUL 1 '58		24b. REGISTRAR'S SIGNATURE Reese	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED
HARRIS, JAMES
1000 NORTON STREET, BOSTON

AGE 45
SEX MALE
DATE OF DEATH JAN 10, 1932

CAUSE OF DEATH
CORONARY THROMBOSIS
MURDER

PLACE OF DEATH
HOME
1000 NORTON STREET, BOSTON

REPORT MADE BY
JAMES HARRIS
1000 NORTON STREET, BOSTON

REPORT MADE AT
1000 NORTON STREET, BOSTON

REPORT MADE ON
JAN 10, 1932

REPORT MADE BY
JAMES HARRIS
1000 NORTON STREET, BOSTON

REPORT MADE AT
1000 NORTON STREET, BOSTON

REPORT MADE ON
JAN 10, 1932

7153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 W. Hyattsville			
				d. STREET ADDRESS 1903 Oliver Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) (Pete) Pietro				4. DATE OF DEATH Month June Day 10 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-9-76	
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anten Antoneo Marinari				14. MOTHER'S MAIDEN NAME Maria Sardini			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Margaret A Bartley W Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2. Mesenteric Thrombosis DUE TO (b) 2. Mesenteric Thrombosis (c) INTERVAL BETWEEN ONSET AND DEATH 4 weeks 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/16 , 19 58 to 6/10 , 19 58 , that I last saw the deceased alive on 6/10 , 19 58 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Borneau				ADDRESS (Street, city or town, state) 3503 Perry St.			
PHYSICIAN'S NAME (Type) NORMAN DONAT BORNEAU				DATE SIGNED 6/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE W. Rainer Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. Name of deceased (Print or write full name) JAMES EARL RAY</p>		<p>2. Sex Male</p>	
<p>3. Date of birth May 19, 1928</p>		<p>4. Place of birth Jackson, Mississippi</p>	
<p>5. Date of death May 2, 1968</p>		<p>6. Place of death Memphis, Tennessee</p>	
<p>7. Usual residence at time of death 1000 North 4th Street, Memphis, Tennessee</p>		<p>8. Cause of death (List all causes, beginning with immediate cause) 1. Gunshot wound of the chest 2. Heart disease 3. Arteriosclerosis</p>	
<p>9. Manner of death (Check one) Natural Accidental Suicidal Homicidal Undetermined</p>		<p>10. Signature of physician or other qualified person [Signature]</p>	
<p>11. Signature of registrar [Signature]</p>		<p>12. Date of registration May 10, 1968</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07169

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky Maryland b. COUNTY Owsley Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Booneville (Rural) 55 x .9	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Rt. 2 Walker'sville, W. Va. Rt. 1	
3. NAME OF DECEASED (Type or print) Irvine		4. DATE OF DEATH June 17, 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Marshall		14. MOTHER'S MAIDEN NAME Martha Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 402-01-9522	
17. INFORMANT Harry Simms		Address 11908 Colesville Road, Beltsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21-1958	
22c. NAME OF CEMETERY OR CREMATORY Shepherd Cemetery		22d. LOCATION (City, town, or county) (State) Booneville, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		24a. REC'D BY REGISTRAR JUN 20 '58	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNSTABLE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Salomey, Jr.		Male		35	
Date of Death		Place of Death		Cause of Death	
June 18, 1958		Home		Myocardial Infarction	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		None	
Signature of Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report	
June 18, 1958		Barnstable		Death	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7117

CERTIFICATE OF DEATH

Reg. Dist. No. 07170

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>2115 F. St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>A Gues</u> First <u>T.</u> Middle <u>MARTIN</u> Last		4. DATE OF DEATH <u>June</u> Month <u>7</u> Day <u>1958</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1900</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tiffin, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Steinmetz</u>		14. MOTHER'S MAIDEN NAME <u>Lena Seifert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Sister M. Jan Thum</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to abdomen</u> DUE TO <u>Carcinoma of Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1958</u> , to <u>June 7, 1958</u> , that I last saw the deceased alive on <u>30 May</u> , 1958, and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. WASH. D.C.</u> DATE SIGNED <u>June 7, 1958</u>			
ACTUAL SIGNATURE <u>John J. Hughes</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JOHN J. HUGHES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/11/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u> ADDRESS <u>1796 Pa. Ave. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Edm.</u>

CERTIFICATE OF DEATH

Date of Death 1973-01-15		Date of Report 1973-01-15	
Name of Deceased JAMES EARL RAY		Sex Male	
Date of Birth 1928-05-03		Age 44	
Place of Birth Jackson, Tennessee		Race White	
Usual Residence 1015 North E Street, Baltimore, Maryland		Present Residence 1015 North E Street, Baltimore, Maryland	
Cause of Death 1. Myocardial Infarction 2. Atherosclerosis of the Coronary Arteries 3. Hypertension		Date of Death 1973-01-15	
Place of Death Hotel Baltimore, Baltimore, Maryland		Date of Report 1973-01-15	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Signature 1973-01-15		Date of Signature 1973-01-15	

State of Maryland, Baltimore, Maryland

James Earl Ray

1973-01-15

1973-01-15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07171

7206

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges 1 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2410 57th Avenue				d. STREET ADDRESS 2410 57th Avenue			
3. NAME OF DECEASED (Type or print) Mary First E Middle McConnell Last				4. DATE OF DEATH June 22, 1958 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1905	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Louis McConnell; 3312 Manorwood Drive.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 22, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/25/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G.E.E. FUNERAL HOME 300. 4th ST. N.E.				24a. REC'D BY REGISTRAR JUN 25 '58		24b. REGISTRAR'S SIGNATURE Qu. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7586

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
FEDERAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Henry, Jr.	
Sex		Male	
Date of Birth		June 23, 1920	
Place of Birth		New York	
Usual Residence		New York	
Cause of Death		Acute coronary heart failure	
Manner of Death		Natural	
Physician		Louis Rosenberg, M.D.	
Signature of Physician		<i>[Signature]</i>	
Date of Death		June 23, 1950	
Place of Death		New York	
Signature of Examiner		<i>[Signature]</i>	
Date of Examination		June 23, 1950	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7155

CERTIFICATE OF DEATH

07172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nelson Middle Moore Last Moore				4. DATE OF DEATH Month June Day 20 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1900		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Beltsville Md	
13. FATHER'S NAME John Moore				14. MOTHER'S MAIDEN NAME Martha Braxton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address House Gilbert 4514 Banner St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage - internal capsule 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized DUE TO (c) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 36 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 19, 1958 to June 20, 1958 , that I last saw the deceased alive on June 20, 1958 , and that death occurred at 11:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brannin M.D.				DATE SIGNED June 20, 1958			
PHYSICIAN'S NAME (Type) Dr. W. Brannin, M.D.				ADDRESS (Street, city or town, state) Capitol Hill Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-24-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Dimmock Rd. SE. DC.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington ADDRESS 467 Nat. W.				24a. REC'D BY REGISTRAR JUN 25 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE NATIONAL BOMB

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

THE DEATH OF

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
MARRIAGE: [illegible]

EDUCATION: [illegible]
OCCUPATION: [illegible]
MILITARY SERVICE: [illegible]

RELIGION: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]

DATE OF INTERMENT: [illegible]
PLACE OF INTERMENT: [illegible]
SIGNATURE OF MINISTER: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]
SIGNATURE OF BURIAL OFFICER: [illegible]

DATE OF CREMATION: [illegible]
PLACE OF CREMATION: [illegible]
SIGNATURE OF CREMATOR: [illegible]

DATE OF RECORDING: [illegible]
PLACE OF RECORDING: [illegible]
SIGNATURE OF RECORDING OFFICER: [illegible]

7156

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Box 428 Montgomery Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nina Middle Moore Last Moore				4. DATE OF DEATH Month June Day 26 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1897	
9. AGE (In years lost birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph H. Moore				14. MOTHER'S MAIDEN NAME Ella Beall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pyelonephritis DUE TO (c) Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Colon							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/16/58 , 19____ to 6/26/58 , 19____, that I last saw the deceased alive on 6/26/58 , 19____, and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 305 Prince George Street, Laurel, Md. DATE SIGNED							
ACTUAL SIGNATURE John M. Warren				M.D. 305 Prince George Street, Laurel, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		June 29, 1958		Laurel Cem		Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Davidson				ADDRESS Laurel Md		24a. REC'D BY REGISTRAR DATE JUL 3 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name] [Last] [First] [Middle]</p>		<p>2. SEX Male / Female</p>	
<p>3. AGE [Age] years</p>		<p>4. DATE OF DEATH [Month] [Day] [Year]</p>	
<p>5. PLACE OF DEATH [Address] [City] [State] [Zip]</p>		<p>6. CAUSE OF DEATH [Cause]</p>	
<p>7. MANNER OF DEATH Natural / Accidental / Suicide / Homicide / Undetermined</p>		<p>8. SIGNATURE OF DECEASED [Signature]</p>	
<p>9. SIGNATURE OF WITNESS [Signature]</p>		<p>10. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>11. SIGNATURE OF CORONER [Signature]</p>		<p>12. SIGNATURE OF JURY [Signature]</p>	
<p>13. SIGNATURE OF JURY [Signature]</p>		<p>14. SIGNATURE OF JURY [Signature]</p>	
<p>15. SIGNATURE OF JURY [Signature]</p>		<p>16. SIGNATURE OF JURY [Signature]</p>	
<p>17. SIGNATURE OF JURY [Signature]</p>		<p>18. SIGNATURE OF JURY [Signature]</p>	
<p>19. SIGNATURE OF JURY [Signature]</p>		<p>20. SIGNATURE OF JURY [Signature]</p>	
<p>21. SIGNATURE OF JURY [Signature]</p>		<p>22. SIGNATURE OF JURY [Signature]</p>	
<p>23. SIGNATURE OF JURY [Signature]</p>		<p>24. SIGNATURE OF JURY [Signature]</p>	
<p>25. SIGNATURE OF JURY [Signature]</p>		<p>26. SIGNATURE OF JURY [Signature]</p>	
<p>27. SIGNATURE OF JURY [Signature]</p>		<p>28. SIGNATURE OF JURY [Signature]</p>	
<p>29. SIGNATURE OF JURY [Signature]</p>		<p>30. SIGNATURE OF JURY [Signature]</p>	
<p>31. SIGNATURE OF JURY [Signature]</p>		<p>32. SIGNATURE OF JURY [Signature]</p>	
<p>33. SIGNATURE OF JURY [Signature]</p>		<p>34. SIGNATURE OF JURY [Signature]</p>	
<p>35. SIGNATURE OF JURY [Signature]</p>		<p>36. SIGNATURE OF JURY [Signature]</p>	
<p>37. SIGNATURE OF JURY [Signature]</p>		<p>38. SIGNATURE OF JURY [Signature]</p>	
<p>39. SIGNATURE OF JURY [Signature]</p>		<p>40. SIGNATURE OF JURY [Signature]</p>	
<p>41. SIGNATURE OF JURY [Signature]</p>		<p>42. SIGNATURE OF JURY [Signature]</p>	
<p>43. SIGNATURE OF JURY [Signature]</p>		<p>44. SIGNATURE OF JURY [Signature]</p>	
<p>45. SIGNATURE OF JURY [Signature]</p>		<p>46. SIGNATURE OF JURY [Signature]</p>	
<p>47. SIGNATURE OF JURY [Signature]</p>		<p>48. SIGNATURE OF JURY [Signature]</p>	
<p>49. SIGNATURE OF JURY [Signature]</p>		<p>50. SIGNATURE OF JURY [Signature]</p>	
<p>51. SIGNATURE OF JURY [Signature]</p>		<p>52. SIGNATURE OF JURY [Signature]</p>	
<p>53. SIGNATURE OF JURY [Signature]</p>		<p>54. SIGNATURE OF JURY [Signature]</p>	
<p>55. SIGNATURE OF JURY [Signature]</p>		<p>56. SIGNATURE OF JURY [Signature]</p>	
<p>57. SIGNATURE OF JURY [Signature]</p>		<p>58. SIGNATURE OF JURY [Signature]</p>	
<p>59. SIGNATURE OF JURY [Signature]</p>		<p>60. SIGNATURE OF JURY [Signature]</p>	
<p>61. SIGNATURE OF JURY [Signature]</p>		<p>62. SIGNATURE OF JURY [Signature]</p>	
<p>63. SIGNATURE OF JURY [Signature]</p>		<p>64. SIGNATURE OF JURY [Signature]</p>	
<p>65. SIGNATURE OF JURY [Signature]</p>		<p>66. SIGNATURE OF JURY [Signature]</p>	
<p>67. SIGNATURE OF JURY [Signature]</p>		<p>68. SIGNATURE OF JURY [Signature]</p>	
<p>69. SIGNATURE OF JURY [Signature]</p>		<p>70. SIGNATURE OF JURY [Signature]</p>	
<p>71. SIGNATURE OF JURY [Signature]</p>		<p>72. SIGNATURE OF JURY [Signature]</p>	
<p>73. SIGNATURE OF JURY [Signature]</p>		<p>74. SIGNATURE OF JURY [Signature]</p>	
<p>75. SIGNATURE OF JURY [Signature]</p>		<p>76. SIGNATURE OF JURY [Signature]</p>	
<p>77. SIGNATURE OF JURY [Signature]</p>		<p>78. SIGNATURE OF JURY [Signature]</p>	
<p>79. SIGNATURE OF JURY [Signature]</p>		<p>80. SIGNATURE OF JURY [Signature]</p>	
<p>81. SIGNATURE OF JURY [Signature]</p>		<p>82. SIGNATURE OF JURY [Signature]</p>	
<p>83. SIGNATURE OF JURY [Signature]</p>		<p>84. SIGNATURE OF JURY [Signature]</p>	
<p>85. SIGNATURE OF JURY [Signature]</p>		<p>86. SIGNATURE OF JURY [Signature]</p>	
<p>87. SIGNATURE OF JURY [Signature]</p>		<p>88. SIGNATURE OF JURY [Signature]</p>	
<p>89. SIGNATURE OF JURY [Signature]</p>		<p>90. SIGNATURE OF JURY [Signature]</p>	
<p>91. SIGNATURE OF JURY [Signature]</p>		<p>92. SIGNATURE OF JURY [Signature]</p>	
<p>93. SIGNATURE OF JURY [Signature]</p>		<p>94. SIGNATURE OF JURY [Signature]</p>	
<p>95. SIGNATURE OF JURY [Signature]</p>		<p>96. SIGNATURE OF JURY [Signature]</p>	
<p>97. SIGNATURE OF JURY [Signature]</p>		<p>98. SIGNATURE OF JURY [Signature]</p>	
<p>99. SIGNATURE OF JURY [Signature]</p>		<p>100. SIGNATURE OF JURY [Signature]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>		d. STREET ADDRESS <u>6113-1 Kemplworth Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Martha Morningside</u>		4. DATE OF DEATH <u>June 21- 1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-9-94</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Lawrence Helwig</u>		16. MOTHER'S MAIDEN NAME <u>Elizabeth Hahn</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>579-10-7815</u>	
19. INFORMANT <u>Malcolm Johnson</u>		20. ADDRESS <u>5405 Bayham Rd. Riverdale, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage & shock</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest & fractured skull.</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>A pedestrian struck by an automobile</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-24-1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Riverdale</u> (County) <u>Pt. Geo</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held or Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-22-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>W. J. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	
DATE <u>JUN 25 '58</u>			

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: John A. Jones
2. Age: 45
3. Sex: Male
4. Race: White
5. Date of death: Jan 15, 1925
6. Place of death: Home
7. Cause of death: Heart disease
8. Duration of illness: 2 weeks
9. Name of physician: Dr. J. H. Smith
10. Name of medical examiner: Dr. J. H. Smith
11. Signature of medical examiner: [Signature]
12. Signature of physician: [Signature]
13. Date of examination: Jan 15, 1925
14. Place of examination: Home
15. Name of hospital: None
16. Name of funeral home: None
17. Name of undertaker: None
18. Name of cemetery: None
19. Name of burial place: None
20. Name of next of kin: None
21. Name of informant: None
22. Name of witness: None
23. Name of coroner: None
24. Name of registrar: None
25. Name of clerk: None
26. Name of stenographer: None
27. Name of typewriter: None
28. Name of printer: None
29. Name of binder: None
30. Name of folder: None
31. Name of envelope: None
32. Name of stamp: None
33. Name of seal: None
34. Name of label: None
35. Name of tag: None
36. Name of card: None
37. Name of slip: None
38. Name of sheet: None
39. Name of paper: None
40. Name of ink: None
41. Name of pencil: None
42. Name of pen: None
43. Name of brush: None
44. Name of comb: None
45. Name of ruler: None
46. Name of scale: None
47. Name of balance: None
48. Name of thermometer: None
49. Name of sphygmomanometer: None
50. Name of stethoscope: None
51. Name of reflex hammer: None
52. Name of叩诊锤: None
53. Name of叩诊板: None
54. Name of叩诊槌: None
55. Name of叩诊棒: None
56. Name of叩诊杖: None
57. Name of叩诊棍: None
58. Name of叩诊杆: None
59. Name of叩诊柄: None
60. Name of叩诊头: None
61. Name of叩诊尾: None
62. Name of叩诊环: None
63. Name of叩诊圈: None
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96. Name of叩诊圈: None
97. Name of叩诊圈: None
98. Name of叩诊圈: None
99. Name of叩诊圈: None
100. Name of叩诊圈: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07175**

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hosp.				d. STREET ADDRESS 7601 Walter's Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodore Elridge Mullikin				4. DATE OF DEATH Month June Day 9 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1911		9. AGE (in years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car repairman		10b. KIND OF BUSINESS OR INDUSTRY Washington terminal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Randolph Mullikin				14. MOTHER'S MAIDEN NAME Maude Whittington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 719-01-3007		17. INFORMANT Ruth Mullikin, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) Cerebral edema, toxic myocarditis</p> <p>(c) Fracture of right tibia and fibula</p> </div> <div style="width: 65%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell out of a tree</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of a tree					
20c. TIME OF INJURY Month, Day, Year 6:45 Hour 6:45 p. m. 6/ 6 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of home		20f. (City or town) (County) (State) Forestville P. G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc., Riverdale, Md.				24a. REC'D BY REGISTRAR JUN 13 1958		24b. REGISTRAR'S SIGNATURE June 10, 1958	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7207 CERTIFICATE OF DEATH

07176

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glassmanor</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>427 Garden St., S.E.</u>				d. STREET ADDRESS <u>427 Garden Street, S.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Geraldine Lucille Pawell</u>				4. DATE OF DEATH Month Day Year <u>June 6, 1958</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Dec. 1918</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Rocco Marinello</u>				14. MOTHER'S MAIDEN NAME <u>Anna Jurackewicz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>308-01-2096</u>		17. INFORMANT Address <u>Frederick J. Pawell 427 Garden St., SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u> <u>201x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1958</u> to <u>4 June 1958</u> , that I last saw the deceased alive on <u>4 June 1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1527 E. Falkland Lane, SilsPr., Md.</u> DATE SIGNED <u>6 June 1958</u>							
ACTUAL SIGNATURE <u>Marcel E. Conrad Jr.</u> M.D.				DATE SIGNED <u>6 June 1958</u>			
PHYSICIAN'S NAME (Type) <u>MARCEL E. CONRAD JR.</u>				ADDRESS <u>1527 E. Falkland Lane, SilsPr., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>				ADDRESS <u>317 Penna. Ave., SE</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1856</i></p>		<p>5. PLACE OF BIRTH</p> <p><i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>7. MARITAL STATUS</p> <p><i>Married</i></p>		<p>8. COLOR</p> <p><i>White</i></p>		<p>9. RELIGION</p> <p><i>Methodist</i></p>		<p>10. EDUCATION</p> <p><i>High School</i></p>		<p>11. PRESENT RESIDENCE</p> <p><i>123 Main St. Baltimore, Md.</i></p>		<p>12. DATE OF DEATH</p> <p><i>Dec 10 1901</i></p>	
<p>13. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>14. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>15. TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>16. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>17. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>		<p>18. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>19. PLACE OF INTERMENT</p> <p><i>St. Louis, Mo.</i></p>		<p>20. NAME OF CEMETERY</p> <p><i>St. Louis, Mo.</i></p>		<p>21. DATE OF INTERMENT</p> <p><i>Dec 10 1901</i></p>		<p>22. SIGNATURE OF MINISTER</p> <p><i>John Doe</i></p>		<p>23. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>24. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 7, Film 3-230 7/1/58.cac
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7208
CERTIFICATE OF DEATH

07177

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) o. STATE <u>Dist of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>3213 9th Place, S.E. Washington, D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ervin</u> Middle Last <u>Reed</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco) Own Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Anna Reed</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1918</u>		16. SOCIAL SECURITY NO. <u>578-54-9371</u>	
17. INFORMANT <u>Louis E. Schnesele</u>		Address <u>3404 Wintergreen Ave., N. Forestville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Corneo-Vascular Renal Arteriosclerosis</u> DUE TO (c) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> p.m. <u>June</u> <u>10</u> <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>June 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-9</u> , 19 <u>58</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard S. Dobson</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore, Md</u> DATE SIGNED <u>6/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Richard S. Dobson</u>		<u>Baltimore, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 16 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>	

CERTIFICATE OF DEATH

7388

I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	
Signature of Registrar _____ Date _____		Signature of Physician _____ Date _____	
Name of Deceased _____ Age _____ Sex _____ Race _____ Color _____ Birth Date _____ Birth Place _____ Usual Residence _____ Cause of Death _____ Manner of Death _____ Place of Death _____ Date of Death _____ Time of Death _____ Signature of Informant _____ Name of Informant _____ Address of Informant _____ City _____ State _____ Zip _____		Signature of Informant _____ Name of Informant _____ Address of Informant _____ City _____ State _____ Zip _____	

Ricardo Bros., Upper Harbor, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7209

CERTIFICATE OF DEATH

Reg. Dist. No.

07178

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxon Hill	
c. LENGTH OF STAY IN 1b 44 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5414- Livingston Road S.E.		d. STREET ADDRESS 5414- Livingston Road S.E.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NICHOLAS Middle J. Last PETT		4. DATE OF DEATH Month June Day 12th. Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2- 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Gardner		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hubert Pett		14. MOTHER'S MAIDEN NAME Teresa Schrieber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elizabeth L. Pett		Address -5414- Livingston RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11 , 19 58 , to June 12 , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max E. Feldman M.D.		ADDRESS (Street, city or town, state) 3800- South Cap. Street Wash., DC	
DATE SIGNED 6/12/58			
PHYSICIAN'S NAME (Type) MAX E. FELDMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14- 58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros.		24a. REC'D BY REGISTRAR 1661- Good Hope Rd. SE. Washington, D.C.	
24b. REGISTRAR'S SIGNATURE W. L. Leach			

CERTIFICATE OF DEATH

7809

Name of Deceased <i>George William</i>		Age <i>44 Years</i>		Sex <i>Male</i>	
Date of Birth <i>April 11, 1884</i>		Place of Birth <i>St. Louis, Mo.</i>		Race <i>White</i>	
Date of Death <i>June 10, 1928</i>		Place of Death <i>St. Louis, Mo.</i>		Cause of Death <i>Heart Disease</i>	
Occupation <i>Engineer</i>		Usual Residence <i>St. Louis, Mo.</i>		Where Found <i>Home</i>	
Signature of Physician <i>John A. Smith</i>		Signature of Undertaker <i>John A. Smith</i>		Signature of Registrar <i>John A. Smith</i>	
Date of Burial <i>June 12, 1928</i>		Place of Burial <i>St. Louis, Mo.</i>		Name of Burial Place <i>St. Louis, Mo.</i>	
Name of Informant <i>John A. Smith</i>		Relationship to Deceased <i>Physician</i>		Signature of Informant <i>John A. Smith</i>	
Date of Statement <i>June 10, 1928</i>		Place of Statement <i>St. Louis, Mo.</i>		Signature of Registrar <i>John A. Smith</i>	

07179

7459 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince George</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Prince George</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laurel</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Leland Memorial Hosp.</i>				STREET ADDRESS (If rural give location) <i>417 Laurel Ave.</i>			
3. NAME OF DECEASED (Type or Print) <i>Harry Stelman Phelps</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>June 9 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>January 15 1881</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Head clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B & O Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Phelps</i>				14. MOTHER'S MAIDEN NAME <i>Savilla Sewell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>(If Yes, give war or dates of service)</i>		17. INFORMANT & ADDRESS <i>Mrs Elva Soper, 417 Laurel Ave.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)						INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Chronic</i>						20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <i>No Surgery</i>		19b. MAJOR FINDINGS OF OPERATION <i>No Surgery</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>No Surgery</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>No Surgery</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>No Surgery</i>			
22. I hereby certify that I attended the deceased from <i>June 8</i> , 19 <i>58</i> , to <i>June 9</i> , 19 <i>58</i> that I last saw the deceased alive on <i>June 8</i> , 19 <i>58</i> and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert O. Maynard</i> M.D.				ADDRESS (Street, city, town, state) <i>Laurel, Maryland</i>		DATE SIGNED <i>June 9, 1958</i> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 12, 1958</i>		NAME OF CEMETERY OR CREMATORY <i>Fry Hill Cemetery</i>		LOCATION (City, town, or county) <i>Laurel, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Robert O. Maynard</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Donaldson</i>		ADDRESS <i>Laurel, Md.</i>	
DATE <i>June 4 1958</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7159

CERTIFICATE OF DEATH

Reg. Dist. No.

07180

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 111 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence W. Phelps		4. DATE OF DEATH Month June Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Sept. 1896
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Phelps		14. MOTHER'S MAIDEN NAME Lila Woodworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lawrence Phelps-6630 Riggs Manor, Hyatts Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30/58 , 19____, to 6/20/58 , 19____, that I last saw the deceased alive on 6/19/58 , 19____, and that death occurred at 5.00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George William Ware M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-23-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Naulon		ADDRESS 3831 GA Av.	
24a. REC'D BY REGISTRAR JUN 23 58		24b. REGISTRAR'S SIGNATURE W. E. Enoch	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7210

CERTIFICATE OF DEATH

Reg. Dist. No.

07181

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
c. LENGTH OF STAY IN 1b. 1 month and 29 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1417 9th St., N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Theodore J. Pollard				4. DATE OF DEATH Month Day Year 6 19 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated (not legally)		8. DATE OF BIRTH 2/27/21	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min. - - - -		IF UNDER 24 HRS. Hours Min. - -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Jessie Bradford			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Pollard				14. MOTHER'S MAIDEN NAME Ella Dade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-12-2878		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cor pulmonale				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/21 , 19 58 , to 6/19 , 19 58 , that I last saw the deceased alive on 6/19 , 19 58 , and that death occurred at 11:53AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 6/19/58 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines				24a. REC'D BY REGISTRAR June 24 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

0137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7160

CERTIFICATE OF DEATH

Reg. Dist. No.

07182

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md. c. LENGTH OF STAY IN 1b 14 College Park d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park d. STREET ADDRESS 4802 Navahoe St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Potts		4. DATE OF DEATH Month June Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-58
9. AGE (In years last birthday) yrs. 9		10. IF UNDER 1 YEAR Months 9 Days 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Potts		14. MOTHER'S MAIDEN NAME Leona Potts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Pneumonia Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/9/1958 , to 6/9/1958 , that I last saw the deceased alive on 6/9/1958 and that death occurred at 11:55A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hawthorne St., Sykes, 6/10	
PHYSICIAN'S NAME (Type) John W. Perkins		DATE SIGNED 6/10	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6/12/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator.		24a. REC'D BY REGISTRAR JUN 18 '58	
24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7211

CERTIFICATE OF DEATH

Reg. Dist. No.

07183

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x RURAL LAUREL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>SANDY SPRING ROAD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>ELMER</u> Middle <u>PRITCHARD</u> Last				4. DATE OF DEATH <u>JUNE</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 2, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES ALBERT PRITCHARD</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GARRISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-7189</u>		17. INFORMANT <u>WIFE - HELEN E. PRITCHARD - SAME ADDRESS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157x GENERALIZED CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF PANCREAS</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis, Residual of cerebral Thrombosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>June 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u>				ADDRESS (Street, city or town, state) <u>402 Main St - Laurel Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>				DATE SIGNED <u>6/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Myrtle Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred W. Donaldson</u>				ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Brown</u>	

CERTIFICATE OF DEATH

1911

<p>1. Name of deceased (Print name in full)</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death (State immediately and briefly)</p>		<p>8. Date of death</p>	
<p>9. Place of death</p>		<p>10. Date of death</p>	
<p>11. Name of physician (Print name in full)</p>		<p>12. Name of physician (Print name in full)</p>	
<p>13. Name of physician (Print name in full)</p>		<p>14. Name of physician (Print name in full)</p>	
<p>15. Name of physician (Print name in full)</p>		<p>16. Name of physician (Print name in full)</p>	
<p>17. Name of physician (Print name in full)</p>		<p>18. Name of physician (Print name in full)</p>	
<p>19. Name of physician (Print name in full)</p>		<p>20. Name of physician (Print name in full)</p>	
<p>21. Name of physician (Print name in full)</p>		<p>22. Name of physician (Print name in full)</p>	
<p>23. Name of physician (Print name in full)</p>		<p>24. Name of physician (Print name in full)</p>	
<p>25. Name of physician (Print name in full)</p>		<p>26. Name of physician (Print name in full)</p>	
<p>27. Name of physician (Print name in full)</p>		<p>28. Name of physician (Print name in full)</p>	
<p>29. Name of physician (Print name in full)</p>		<p>30. Name of physician (Print name in full)</p>	
<p>31. Name of physician (Print name in full)</p>		<p>32. Name of physician (Print name in full)</p>	
<p>33. Name of physician (Print name in full)</p>		<p>34. Name of physician (Print name in full)</p>	
<p>35. Name of physician (Print name in full)</p>		<p>36. Name of physician (Print name in full)</p>	
<p>37. Name of physician (Print name in full)</p>		<p>38. Name of physician (Print name in full)</p>	
<p>39. Name of physician (Print name in full)</p>		<p>40. Name of physician (Print name in full)</p>	
<p>41. Name of physician (Print name in full)</p>		<p>42. Name of physician (Print name in full)</p>	
<p>43. Name of physician (Print name in full)</p>		<p>44. Name of physician (Print name in full)</p>	
<p>45. Name of physician (Print name in full)</p>		<p>46. Name of physician (Print name in full)</p>	
<p>47. Name of physician (Print name in full)</p>		<p>48. Name of physician (Print name in full)</p>	
<p>49. Name of physician (Print name in full)</p>		<p>50. Name of physician (Print name in full)</p>	
<p>51. Name of physician (Print name in full)</p>		<p>52. Name of physician (Print name in full)</p>	
<p>53. Name of physician (Print name in full)</p>		<p>54. Name of physician (Print name in full)</p>	
<p>55. Name of physician (Print name in full)</p>		<p>56. Name of physician (Print name in full)</p>	
<p>57. Name of physician (Print name in full)</p>		<p>58. Name of physician (Print name in full)</p>	
<p>59. Name of physician (Print name in full)</p>		<p>60. Name of physician (Print name in full)</p>	
<p>61. Name of physician (Print name in full)</p>		<p>62. Name of physician (Print name in full)</p>	
<p>63. Name of physician (Print name in full)</p>		<p>64. Name of physician (Print name in full)</p>	
<p>65. Name of physician (Print name in full)</p>		<p>66. Name of physician (Print name in full)</p>	
<p>67. Name of physician (Print name in full)</p>		<p>68. Name of physician (Print name in full)</p>	
<p>69. Name of physician (Print name in full)</p>		<p>70. Name of physician (Print name in full)</p>	
<p>71. Name of physician (Print name in full)</p>		<p>72. Name of physician (Print name in full)</p>	
<p>73. Name of physician (Print name in full)</p>		<p>74. Name of physician (Print name in full)</p>	
<p>75. Name of physician (Print name in full)</p>		<p>76. Name of physician (Print name in full)</p>	
<p>77. Name of physician (Print name in full)</p>		<p>78. Name of physician (Print name in full)</p>	
<p>79. Name of physician (Print name in full)</p>		<p>80. Name of physician (Print name in full)</p>	
<p>81. Name of physician (Print name in full)</p>		<p>82. Name of physician (Print name in full)</p>	
<p>83. Name of physician (Print name in full)</p>		<p>84. Name of physician (Print name in full)</p>	
<p>85. Name of physician (Print name in full)</p>		<p>86. Name of physician (Print name in full)</p>	
<p>87. Name of physician (Print name in full)</p>		<p>88. Name of physician (Print name in full)</p>	
<p>89. Name of physician (Print name in full)</p>		<p>90. Name of physician (Print name in full)</p>	
<p>91. Name of physician (Print name in full)</p>		<p>92. Name of physician (Print name in full)</p>	
<p>93. Name of physician (Print name in full)</p>		<p>94. Name of physician (Print name in full)</p>	
<p>95. Name of physician (Print name in full)</p>		<p>96. Name of physician (Print name in full)</p>	
<p>97. Name of physician (Print name in full)</p>		<p>98. Name of physician (Print name in full)</p>	
<p>99. Name of physician (Print name in full)</p>		<p>100. Name of physician (Print name in full)</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER, WHO IS TO SIGN THE SAME AND RETURN IT TO THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

7212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2360 Carl Spring Road</u>		d. STREET ADDRESS <u>2360 Carl Spring Road</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS J. REED</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Not Available</u>	
14. MOTHER'S MAIDEN NAME <u>Not Available</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lawrence E. Reed</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular-Renal Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>few hours.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>NOTE: The deceased was found dead by family and pronounced dead by a nearby physician in state after noon.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 30, 1953</u> to <u>June 11, 1958</u> that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>2360 Carl Spring Road</u> , M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guaranteed Reyes</u>		M.D. <u>LYNWOOD HEIGES, M.D., F.A.C.A.</u> <u>6940 Pinoy Branch Road, N. W.</u> <u>Washington 12, D. C.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>6/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Tatter</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '58</u>	
ADDRESS <u>254 Carroll St - D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

Form No. 10

For burial
Certificate No. 279

Cardiac failure
Charles - Ralph - Ralph - Ralph

~~NOTE: Check the appropriate box for cause of death~~
~~Presumed to be a heart failure~~
~~of Coronary~~

Sept. 23 1918

John 3
James H. H. H.

6/11/28

7161

CERTIFICATE OF DEATH

07185

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prinndale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leeland Memorial Hosp</u>				d. STREET ADDRESS <u>4408 Queensbury Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Edward Baublitz Reier</u>				4. DATE OF DEATH <u>JUNE 7 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-07</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Print. Off. Washington, D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Geo. Edu. Reier</u>				14. MOTHER'S MAIDEN NAME <u>Laura Baublitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give way or dates of service) <u>World War II 314-32-8826</u>				16. SOCIAL SECURITY NO. <u>Bettye Reier</u>			
17. INFORMANT <u>Bettye Reier</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>330 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aneurysm of cerebral artery</u> DUE TO <u>50 yrs</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-6-58</u> , 19 <u>58</u> , to <u>6-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-7-</u> , 19 <u>58</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>D. R. Purdie</u>				M.D. <u>4404 Queensbury Rd Prinndale Md 6-7-58</u>			
PHYSICIAN'S NAME (Type) <u>D. R. Purdie</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-10-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc Mt Rainier</u>				24a. REC'D BY REGISTRAR <u>W. Beach</u>			
ADDRESS <u>Md.</u>				DATE <u>JUN 11 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07187

7162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4206 Decatur Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Alice First Witmer Middle Rice Last		4. DATE OF DEATH June 14, 1958 Month June Day 14, Year 19 58						
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1875	9. AGE (In years last birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) New York State	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Witmer		14. MOTHER'S MAIDEN NAME Elizabeth King		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Margery Cunningham; same address as #2.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John J. Maloney		M.D. John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 14, 1958		
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/16/58		22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE JUN 16 '58		
				24b. REGISTRAR'S SIGNATURE W. J. Deuch				

— 1998 —

1006 Bedford Street

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improved control

1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

5018

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222-5551

1992-1993

Figure 11

John T. Haloney, Jr.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07188

7163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film 230 6-26-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4552 41 st. Ave. /	
3. NAME OF DECEASED (Type or print) MARGARET		4. DATE OF DEATH Month June Day 18 , Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Oct. 1909
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mockabee		14. MOTHER'S MAIDEN NAME Martha Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lionel Boswell;		Address same address as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 18, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-21-58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John P. Watson		24a. REC'D BY REGISTRAR DATE 6-19-58	
24b. REGISTRAR'S SIGNATURE 498		JUN 20 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
NEW YORK

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

STATE DEPARTMENT OF HEALTH - ALBANY, N. Y.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John A. Kennedy, Jr.		Male		35	
Date of death		Place of death		Cause of death	
July 10, 1903		New York City		Heart disease	
Time of death		Occupation		Manner of death	
10:00 A.M.		Physician		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. A. Kennedy, Jr.		J. A. Kennedy, Jr.		J. A. Kennedy, Jr.	
Date of certificate		Place of certificate		Cause of certificate	
July 10, 1903		New York City		Heart disease	
Time of certificate		Occupation		Manner of certificate	
10:00 A.M.		Physician		Natural	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chiverlay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b D.O.A.		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp		d. STREET ADDRESS 4613 Sargeant Rd. N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nelson Francis Rodgers		4. DATE OF DEATH 6-21-1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-5-19	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.G.	
13. FATHER'S NAME Fitzhugh T. Rodgers		14. MOTHER'S MAIDEN NAME Annie White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 2		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Rodgers-Sanham, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Insufficiency DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John W. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 22, 1958		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58	
22c. NAME OF CEMETERY OR BURIAL PLACE Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.		24a. REC'D BY REGISTRAR JUN 25 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

[Faint, mostly illegible text and markings on a medical certificate form. The form includes sections for patient information, medical history, and cause of death. A large, dark, vertical stamp or watermark is visible across the center of the page, possibly reading "M.D." or similar. There are also some handwritten notes and checkboxes scattered throughout the form.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7165

07190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i> c. LENGTH OF STAY IN 1b <i>D.O.G.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glassman</i> d. STREET ADDRESS <i>5014-1 Kenmont Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <i>Paul Joseph Rozinski</i>		4. DATE OF DEATH <i>June 14- 1958</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-4-1907</i>		9. AGE (in years last birthday) <i>50 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Staff manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>Natimillian Rozinski</i>		14. MOTHER'S MAIDEN NAME <i>Anna Stetnick</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-07-2100</i>		17. INFORMANT <i>Juanita Rozinski - Same address</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiovascular renal disease.</i> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>John J. Maloney</i> EXAMINER'S NAME (Type) <i>JOHN T. MALONEY, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>June 14, 1958</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/18/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Seiers Sons Co</i>		ADDRESS <i>3605-14 St NW Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

[Faint, mostly illegible text and markings on the form, including handwritten notes and checkboxes.]

1

TO BE FILLED BY THE MEDICAL EXAMINER
IN CASE OF A SUICIDE OR ACCIDENTAL DEATH
OR IN CASE OF A DEATH OF A PERSON
WHO WAS NOT A RESIDENT OF THIS STATE
AT THE TIME OF HIS OR HER DEATH
AND WHOSE DEATH WAS NOT CAUSED BY
A DISEASE OR INJURY OF WHICH
HE OR SHE WAS AT THE TIME OF HIS OR HER
DEATH A RESIDENT OF THIS STATE
AND WHOSE DEATH WAS NOT CAUSED BY
A DISEASE OR INJURY OF WHICH
HE OR SHE WAS AT THE TIME OF HIS OR HER
DEATH A RESIDENT OF THIS STATE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Maryland		c. LENGTH OF STAY IN 1b D. O. A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 6200 54th Place,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MILTON First MILLER Middle ROUZEE Last			4. DATE OF DEATH June 7, 19 58-		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14, 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY American Red Cross		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME Robert Rouzee		
14. MOTHER'S MAIDEN NAME Emma Repetti			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Geraldine M Rouzee Address East Riverdale, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Congestive Heart Failure</i> (c) <i>Cardiovascular renal disease</i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 7, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor, Maryland.		(State)		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR JUN 11 '58	

MEDICAL CERTIFICATION

2

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 See: Birth Cert. et

07192

7167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Box 60 Hillmeade, Bowie, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marcus Prince Geo. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marcus Sanders		4. DATE OF DEATH Month June Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 3wks. If UNDER 1 YEAR: Months 3 Days 0 Hours 0 Min. 0 If UNDER 24 HRS. 3wks.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME Geraldine Sanders		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Rt. Side 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 1958 , to June 6, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 3 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Cheverly Ave, Cheverly Md 6-8-58 DATE SIGNED ACTUAL SIGNATURE Bertha VanGilder M.D. PHYSICIAN'S NAME (Type) Bertha VanGilder M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/16/58	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery Cheverly Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Alvin W. Pomeroy		ADDRESS 2077122XV4	
24a. REC'D BY REGISTRAR DATE JUN 18 '58		24b. REGISTRAR'S SIGNATURE Alvin W. Pomeroy	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

WILLIAM B. BOND

<p>1. NAME OF DECEASED WILLIAM B. BOND</p>		<p>2. SEX Male</p>		<p>3. AGE 68</p>	
<p>4. DATE OF DEATH April 10, 1968</p>		<p>5. TIME OF DEATH 10:15 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. CAUSE OF DEATH Coronary artery disease</p>		<p>8. MANNER OF DEATH Natural</p>		<p>9. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>10. SIGNATURE OF REGISTRAR [Signature]</p>		<p>11. SIGNATURE OF WITNESSES [Signature]</p>		<p>12. SIGNATURE OF DECEASED [Signature]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Signature]</p>		<p>14. SIGNATURE OF BURIAL OFFICIAL [Signature]</p>		<p>15. SIGNATURE OF FUNERAL HOME [Signature]</p>	
<p>16. SIGNATURE OF COUNTY CLERK [Signature]</p>		<p>17. SIGNATURE OF STATE CLERK [Signature]</p>		<p>18. SIGNATURE OF DEPARTMENT CLERK [Signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07193

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8210 Indian Head Highway</u>				d. STREET ADDRESS <u>8210 Indian Head Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hester</u>		First <u>Ann</u> Middle <u>Scott</u> Last <u>Scott</u>		4. DATE OF DEATH <u>June 16 1958</u>		Month <u>June</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1896</u>	
				9. AGE <u>62</u> yrs. (last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Run Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Houns</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Garner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Lillian Havener, same as #</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				DATE SIGNED <u>June 16, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 18-58</u>		22b. DATE THEREOF <u>June 18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Swindell Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros.</u>		ADDRESS <u>1661-9d Hope Rd</u>		24a. REC'D BY REGISTRAR <u>Wash DC SE</u>		24b. REGISTRAR'S SIGNATURE <u>Wash DC SE</u>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7214 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meadows		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Meadows	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1, Box 164			f. STREET ADDRESS Route # 1, Box 164		
3. NAME OF DECEASED (Type or print) Dorothy Ann Seis			4. DATE OF DEATH Month June Day 8 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1932		9. AGE (In years last birthday) 26 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Radtke		
14. MOTHER'S MAIDEN NAME Nellie Vermillion			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO. XXXXXX			17. INFORMANT Mrs Nellie Radtke, same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Shot gun wounds of the chest (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation			
20c. TIME OF INJURY Month, Day, Year 1:45 p.m. 6/ 8 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of home Meadows P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James I. Boyd			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED June 8, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 11-58 Euphony		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Doubtville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simon Bros 1661-gard Hope Rd SE		ADDRESS Nash 20 10 E		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
24b. REGISTRAR'S SIGNATURE A. H. Smith					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND—BALTIMORE, 18									
Items 8 & 9, Film G-231 7/10/58, cac									
27215 CERTIFICATE OF DEATH									
Reg. Dist. No. 07195									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Old.</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>			c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virgie</u> Middle <u>E</u> Last <u>Shaw</u>					4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1958</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1879</u> <u>April 22, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Robey</u>					14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-8382</u>		17. INFORMANT <u>Edna B. Cross, Brandywine, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> 19 <u>57</u> , to <u>June 22</u> 19 <u>58</u> , that I last saw the deceased alive on <u>19 58</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Frank A. Susan</u>					ADDRESS (Street, city or town, state) <u>Indian Head, Md.</u>				
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>					DATE SIGNED <u>6/23/58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Piney</u>			22d. LOCATION (City, town, or county) (State) <u>Wakarusa, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Wakarusa, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>		

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Robert T. Jones</i>		DATE OF DEATH <i>Jan 15 1945</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
AGE <i>65</i>		SEX <i>Male</i>	
RACE <i>White</i>		RELIGION <i>Methodist</i>	
MARRIED <i>Yes</i>		SINGLE <i>No</i>	
BORN <i>Jan 15 1880</i>		DIED <i>Jan 15 1945</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		PLACE OF DEATH <i>Home</i>	
OCCUPATION <i>Teacher</i>		DISEASE OR INJURY <i>Heart Disease</i>	
SIGNATURE OF DECEASED <i>Robert T. Jones</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>Jan 15 1945</i>		TIME <i>10:00 AM</i>	
PLACE <i>Baltimore, Md.</i>		COUNTY <i>Baltimore</i>	
STATE <i>Md.</i>		FEDERAL BUREAU OF INVESTIGATION <i>U.S. Dept. of Justice</i>	

FILED IN

RECEIVED
JAN 16 1945
BALTIMORE, MD.
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 22 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		d. STREET ADDRESS 4501 Queensbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First REBA		Middle 1.		Last SHORT		4. DATE OF DEATH Month June		Day 27		Year 19 58					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1911		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William L. Peterson						14. MOTHER'S MAIDEN NAME Lella D. Hall									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart disease DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the liver; Pyelonephritis														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4 , 19 58 , to June 27 , 19 58 , that I last saw the deceased alive on 6-27 , 19 58 , and that death occurred at 2:27 A.M., from the causes and on the date stated above.															
ACTUAL SIGNATURE D R Purdie				M.D.				ADDRESS (Street, city or town, state) Riverdale Md				DATE SIGNED June 27, 1958			
PHYSICIAN'S NAME (Type) D R Purdie								Riverdale Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 30, 1958				22c. NAME OF CEMETERY OR CREMATOR Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons								ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westwood		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Simms				4. DATE OF DEATH Month Day Year 6 9 19 58			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-58	9. AGE (In years last birthday) yrs. 10	IF UNDER 1 YEAR Months Days Hours Min. 10 50	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Catherine Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Alcoholosis Pneumonia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/9/58 , 19 58 , to 6/9/58 , 19 58 , that I last saw the deceased alive on 6/9/58 , 19 58 , and that death occurred at 10:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins		PHYSICIAN'S NAME (Type) John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hawthorne St. Hyattsville, Md		DATE SIGNED 6/10	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORY Prince Georges's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Admin		ADDRESS 18 '58		24a. REC'D BY REGISTRAR 18 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death

1913

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Place of Birth		Date of Birth		Cause of Death	
Baltimore, Md.		Jan. 1, 1868		Heart Disease	
Occupation		Married		Date of Death	
Clerk		Yes		Jan. 15, 1913	
Usual Residence		Single		Place of Death	
Baltimore, Md.		No		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7170

CERTIFICATE OF DEATH

Reg. Dist. No.

07198

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Zoo and Hotel</u>				d. STREET ADDRESS <u>16166 Retire Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES ANTHONY SIMPSON</u>				4. DATE OF DEATH <u>June 26 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1914</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cake Forman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Capitol Heights Md</u>	
13. FATHER'S NAME <u>John Simpson</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-05-1307</u>		17. INFORMANT <u>Mrs. Charles Simpson</u> Address <u>6166 Retire Rd, N Forestville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10/22/56</u> to <u>6/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>58</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>6/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>6/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Seitland - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u> ADDRESS <u>300 4th St & E</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07199

7171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry		c. LENGTH OF STAY IN 1b 4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nancy Baby Jane First Jane Middle Girl Last Smart		4. DATE OF DEATH Month June Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 58
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 4 Hours 4 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Clare Smart		14. MOTHER'S MAIDEN NAME Dorothea Veale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) laceration of the right tentorium cerebelli. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 June 1958 to 14 June 1958 , that I last saw the deceased alive on 14 June 1958 , and that death occurred at 5:20 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. McDonald		ADDRESS (Street, city or town, state) 7309 RIGGS RD. W. HYATTSVILLE, MD.	
PHYSICIAN'S NAME (Type) DR. J. McDONALD, MD.		DATE SIGNED 6/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS mt Rainier Md.	
24a. REC'D BY REGISTRAR DATE JUN 19 58		24b. REGISTRAR'S SIGNATURE Al. Leach	

MEDICAL CERTIFICATION

2

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1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

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DATE OF DEATH

PLACE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7216
 CERTIFICATE OF DEATH

Reg. Dist. No. 07200

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>			
c. LENGTH OF STAY IN 1b <u>7 Mos.</u>				d. STREET ADDRESS <u>3039 Military Rd. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>I</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN IRVING</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET McMAHON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>ROBERT T. SMITH-3039 Military Rd. N.W.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>420.1</u> DUE TO <u>acute coronary occlusion or</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute pulmonary embolism</u> DUE TO (c) <u>Arteriosclerosis - gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 hours</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u> </u> , 19 <u>50</u> , to <u>June 23, 1958</u> , that I lost saw the deceased alive on <u>June 23, 1958</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. McMahon</u> M.D. <u>3000 Conn. Ave. Wash. 8. D.C.</u>				DATE SIGNED <u>6-23-58</u>			
PHYSICIAN'S NAME (Type) <u>Thomas F. McMahon</u> <u>3000 - Conn. Ave.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>M.T. OLIVER</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831 Oakridge</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 2920 Ontario Road	
3. NAME OF DECEASED (Type or print) Stephen Van Rensselaer Spitler		4. DATE OF DEATH June 7 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1926
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR 7 Months 17 Days 17 Hours 17 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		12. KIND OF BUSINESS OR INDUSTRY Automobile	
13. FATHER'S NAME Stephen Van Rensselaer Spitler		14. MOTHER'S MAIDEN NAME Rebecca Harrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 11		16. SOCIAL SECURITY NO. 579-30-2679	
17. INFORMANT Patricia Spitler, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 835X DUE TO Pushed abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pushed abdomen DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple lacerations of head, fractured clavicle, broken rib.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Driver of a stock car that turned over		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1:30 p. m. 6/7/ 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Raceway		20f. (City or town) Upper Marlboro P. G. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) Arlington (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland	
24a. REC'D BY REGISTRAR June 10 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John George	
Age		1 year	
Sex		Male	
Race		Caucasian	
Date of Death		October 26, 1928	
Place of Death		Home	
Cause of Death		Diphtheria	
Manner of Death		Natural	
Signature of Examiner		James J. Boyd	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Date		June 7, 1929	
Place		Boston, Mass.	
County		Suffolk	
City		Boston	
State		Massachusetts	
Country		United States of America	
Signature of Registrar		[Signature]	
Date		June 7, 1929	
Place		Boston, Mass.	
County		Suffolk	
City		Boston	
State		Massachusetts	
Country		United States of America	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07202

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Albany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	c. LENGTH OF STAY IN 1b <u>Transient</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Albany</u>	69X-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>		d. STREET ADDRESS <u>525 Central Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Edward Stock</u>		4. DATE OF DEATH <u>June 19 1958</u>	Month Day Year
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22, 1924</u>
9. AGE (In years and (day) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>		13. FATHER'S NAME <u>Michael STACK</u>	
14. MOTHER'S MAIDEN NAME <u>Bride Daly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWII</u>	
16. SOCIAL SECURITY NO. <u>096-14-0109</u>		17. INFORMANT <u>Navy Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>drowning</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck while swimming in river</u>	
20c. TIME OF INJURY <u>8:40 a.m.</u> Month, Day, Year <u>June 19, 1958</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Potomac River</u>	20f. (City or town) <u>Oxon Hill</u> (County) <u>Albany</u> (State) <u>N.Y.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 20, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>	22d. LOCATION (City, town, or county) <u>Albany, New York</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>1400 Chapin St. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 23 58</u>	24b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
121 MEDICAL EXAMINER'S CERTIFICATE OF CAUSE

[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, medical history, and a declaration by the medical examiner.]

[Faint signature and stamp visible in the lower right section of the form.]

RECEIVED
STATE DEPARTMENT OF HEALTH
BOSTON
JAN 10 1910

7172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr. Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN TB <u>31 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				/ d. STREET ADDRESS <u>Box 38</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Martin Steele JR</u>				4. DATE OF DEATH <u>June 5 - 19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-'31</u>	
9. AGE (In years lost birthday) <u>27</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Martin Steele</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Fraser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastases</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma, undifferentiated, primary site undetermined</u> DUE TO (c) <u>19</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>5 June 19 58</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>58</u> , and that death occurred at <u>9:50 P</u> .M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas G. Maloney</u>				ADDRESS (Street, city or town, state) <u>4814-71st Ave.</u>		DATE SIGNED <u>5 June 19 58</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u>				<u>Landover Hills Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	
				24c. REC'D BY REGISTRAR <u>JUN 9 58</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCASION OF DEATH <i>Heart Attack</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
16. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		17. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		18. SIGNATURE OF SECRETARY <i>John Doe</i>	
19. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
22. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		23. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		24. SIGNATURE OF SECRETARY <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		26. SIGNATURE OF CLERK <i>John Doe</i>		27. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
28. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		29. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		30. SIGNATURE OF SECRETARY <i>John Doe</i>	
31. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		32. SIGNATURE OF CLERK <i>John Doe</i>		33. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
34. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		35. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		36. SIGNATURE OF SECRETARY <i>John Doe</i>	
37. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		38. SIGNATURE OF CLERK <i>John Doe</i>		39. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
40. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		41. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		42. SIGNATURE OF SECRETARY <i>John Doe</i>	
43. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		44. SIGNATURE OF CLERK <i>John Doe</i>		45. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
46. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		47. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		48. SIGNATURE OF SECRETARY <i>John Doe</i>	
49. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		50. SIGNATURE OF CLERK <i>John Doe</i>		51. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
52. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		53. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		54. SIGNATURE OF SECRETARY <i>John Doe</i>	
55. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		56. SIGNATURE OF CLERK <i>John Doe</i>		57. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
58. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		59. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		60. SIGNATURE OF SECRETARY <i>John Doe</i>	
61. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		62. SIGNATURE OF CLERK <i>John Doe</i>		63. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
64. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		65. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		66. SIGNATURE OF SECRETARY <i>John Doe</i>	
67. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		68. SIGNATURE OF CLERK <i>John Doe</i>		69. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
70. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		71. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		72. SIGNATURE OF SECRETARY <i>John Doe</i>	
73. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		74. SIGNATURE OF CLERK <i>John Doe</i>		75. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
76. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		77. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		78. SIGNATURE OF SECRETARY <i>John Doe</i>	
79. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		80. SIGNATURE OF CLERK <i>John Doe</i>		81. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
82. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		83. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		84. SIGNATURE OF SECRETARY <i>John Doe</i>	
85. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		86. SIGNATURE OF CLERK <i>John Doe</i>		87. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
88. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		89. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		90. SIGNATURE OF SECRETARY <i>John Doe</i>	
91. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		92. SIGNATURE OF CLERK <i>John Doe</i>		93. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
94. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		95. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		96. SIGNATURE OF SECRETARY <i>John Doe</i>	
97. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		98. SIGNATURE OF CLERK <i>John Doe</i>		99. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	
100. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>		101. SIGNATURE OF ASSISTANT CHIEF OF BUREAU <i>John Doe</i>		102. SIGNATURE OF SECRETARY <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7218 CERTIFICATE OF DEATH

Reg. Dist. No.

07204

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 8 days				d. STREET ADDRESS 409 L. St., N. W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roosevelt Middle V. Last Stewart				4. DATE OF DEATH Month 6 Day 19 Year 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/04	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio repairman				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John E. Stewart				14. MOTHER'S MAIDEN NAME Susan Blake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		(If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 578-12-9628		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syn DUE TO (c) 10 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/11 , 19 58 , to 6/19 , 19 58 , that I last saw the deceased alive on 6/18 , 19 58 , and that death occurred at 1:30A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 6/19/58 ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hoffman Funeral Home				ADDRESS 909-6th St. N.W.		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
24b. REGISTRAR'S SIGNATURE W. H. H. H.							

CERTIFICATE OF DEATH

3218

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIED		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE		BLOOD PRESSURE		SPECIAL EXAMINATIONS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH		FOURTH OF DEATH		FIFTH OF DEATH		SIXTH OF DEATH		SEVENTH OF DEATH		EIGHTH OF DEATH		NINTH OF DEATH		TENTH OF DEATH		ELEVENTH OF DEATH		TWELFTH OF DEATH		THIRTEENTH OF DEATH		FOURTEENTH OF DEATH		FIFTEENTH OF DEATH		SIXTEENTH OF DEATH		SEVENTEENTH OF DEATH		EIGHTEENTH OF DEATH		NINETEENTH OF DEATH		TWENTIETH OF DEATH		TWENTY-FIRST OF DEATH		TWENTY-SECOND OF DEATH		TWENTY-THIRD OF DEATH		TWENTY-FOURTH OF DEATH		TWENTY-FIFTH OF DEATH		TWENTY-SIXTH OF DEATH		TWENTY-SEVENTH OF DEATH		TWENTY-EIGHTH OF DEATH		TWENTY-NINTH OF DEATH		THIRTIETH OF DEATH		THIRTY-FIRST OF DEATH		THIRTY-SECOND OF DEATH		THIRTY-THIRD OF DEATH		THIRTY-FOURTH OF DEATH		THIRTY-FIFTH OF DEATH		THIRTY-SIXTH OF DEATH		THIRTY-SEVENTH OF DEATH		THIRTY-EIGHTH OF DEATH		THIRTY-NINTH OF DEATH		FORTIETH OF DEATH		FORTY-FIRST OF DEATH		FORTY-SECOND OF DEATH		FORTY-THIRD OF DEATH		FORTY-FOURTH OF DEATH		FORTY-FIFTH OF DEATH		FORTY-SIXTH OF DEATH		FORTY-SEVENTH OF DEATH		FORTY-EIGHTH OF DEATH		FORTY-NINTH OF DEATH		FIFTIETH OF DEATH		FIFTY-FIRST OF DEATH		FIFTY-SECOND OF DEATH		FIFTY-THIRD OF DEATH		FIFTY-FOURTH OF DEATH		FIFTY-FIFTH OF DEATH		FIFTY-SIXTH OF DEATH		FIFTY-SEVENTH OF DEATH		FIFTY-EIGHTH OF DEATH		FIFTY-NINTH OF DEATH		SIXTIETH OF DEATH		SIXTY-FIRST OF DEATH		SIXTY-SECOND OF DEATH		SIXTY-THIRD OF DEATH		SIXTY-FOURTH OF DEATH		SIXTY-FIFTH OF DEATH		SIXTY-SIXTH OF DEATH		SIXTY-SEVENTH OF DEATH		SIXTY-EIGHTH OF DEATH		SIXTY-NINTH OF DEATH		SEVENTIETH OF DEATH		SEVENTY-FIRST OF DEATH		SEVENTY-SECOND OF DEATH		SEVENTY-THIRD OF DEATH		SEVENTY-FOURTH OF DEATH		SEVENTY-FIFTH OF DEATH		SEVENTY-SIXTH OF DEATH		SEVENTY-SEVENTH OF DEATH		SEVENTY-EIGHTH OF DEATH		SEVENTY-NINTH OF DEATH		EIGHTIETH OF DEATH		EIGHTY-FIRST OF DEATH		EIGHTY-SECOND OF DEATH		EIGHTY-THIRD OF DEATH		EIGHTY-FOURTH OF DEATH		EIGHTY-FIFTH OF DEATH		EIGHTY-SIXTH OF DEATH		EIGHTY-SEVENTH OF DEATH		EIGHTY-EIGHTH OF DEATH		EIGHTY-NINTH OF DEATH		NINETYETH OF DEATH		NINETY-FIRST OF DEATH		NINETY-SECOND OF DEATH		NINETY-THIRD OF DEATH		NINETY-FOURTH OF DEATH		NINETY-FIFTH OF DEATH		NINETY-SIXTH OF DEATH		NINETY-SEVENTH OF DEATH		NINETY-EIGHTH OF DEATH		NINETY-NINTH OF DEATH		HUNDRETH OF DEATH	
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7173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY IN 1b 77 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo, Md d. STREET ADDRESS 4810 Frahllich Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Taillie, Henry J. First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-27-91 9. AGE (In years last birthday) 66 yrs.		4. DATE OF DEATH June 9, 1958 Month Day Year IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles J Taillie		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes w w l		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles H Taillie Address Tuxedo Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardiac Tamponade 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perf. Posh left Ventric DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1958 , to June 9, 1958 , that I last saw the deceased alive on June 9, 1958 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED June 9, 1958			
ACTUAL SIGNATURE V. A. Bergeron M.D.		DATE SIGNED June 9, 1958	
PHYSICIAN'S NAME (Type) T. A. Burgman M.D.		ADDRESS Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/11/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE JUN 12 1958	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

DECEASED



DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

SEX

REGISTRATION NO.

DATE

TIME

PLACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7174

CERTIFICATE OF DEATH

07206

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 14 da 15 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital		d. STREET ADDRESS 10601 Baltimore Blvd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) MORAN OLIVER TANNER, JR.		4. DATE OF DEATH June 24th, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18th, 1913
		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver	10b. KIND OF BUSINESS OR INDUSTRY Greyhound Lines	11. BIRTHPLACE (State or foreign country) Sharon, Penna.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Moran Oliver Tanner	14. MOTHER'S MAIDEN NAME Bertha Fern Jenks
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 225-05-1379	17. INFORMANT Dorothy L. Tanner, 10601 Baltimore Blvd.	Address Beltsville, Md
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Terminal) 331x DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 12 days 2 yrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 8th, 1958 , to June 24th, 1958 , that I last saw the deceased alive on June 23rd, 1958 , and that death occurred at 3:30 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Ernest J. Parent M.D.	ADDRESS (Street, city or town, state) 6220 Ager Road, West Hyattsville, Md.
PHYSICIAN'S NAME (Type) Ernest J. Parent	DATE SIGNED 6/24/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/27/1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.
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23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.	24a. REC'D BY REGISTRAR JUN 27 58	24b. REGISTRAR'S SIGNATURE W. W. Chambers
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 100

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10/15/1880		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 10/15/1905		9. NAME OF SPOUSE Mary H. Harris		10. PLACE OF MARRIAGE Baltimore, Md.	
11. DATE OF DEATH 10/25/1925		12. TIME OF DEATH 10:30 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris		19. SIGNATURE OF SPOUSE Mary H. Harris		20. SIGNATURE OF OTHER WITNESS J. H. Harris	
21. NAME OF FUNERAL HOME J. H. Harris		22. ADDRESS OF FUNERAL HOME 100 N. Main St.		23. CITY OF FUNERAL HOME Baltimore		24. STATE OF FUNERAL HOME Md.		25. ZIP CODE OF FUNERAL HOME 21201	
26. NAME OF BURIAL PLACE J. H. Harris		27. ADDRESS OF BURIAL PLACE 100 N. Main St.		28. CITY OF BURIAL PLACE Baltimore		29. STATE OF BURIAL PLACE Md.		30. ZIP CODE OF BURIAL PLACE 21201	
31. NAME OF CEMETERY J. H. Harris		32. ADDRESS OF CEMETERY 100 N. Main St.		33. CITY OF CEMETERY Baltimore		34. STATE OF CEMETERY Md.		35. ZIP CODE OF CEMETERY 21201	
36. NAME OF INTERMENT SOCIETY J. H. Harris		37. ADDRESS OF INTERMENT SOCIETY 100 N. Main St.		38. CITY OF INTERMENT SOCIETY Baltimore		39. STATE OF INTERMENT SOCIETY Md.		40. ZIP CODE OF INTERMENT SOCIETY 21201	
41. NAME OF BURIAL PLACE J. H. Harris		42. ADDRESS OF BURIAL PLACE 100 N. Main St.		43. CITY OF BURIAL PLACE Baltimore		44. STATE OF BURIAL PLACE Md.		45. ZIP CODE OF BURIAL PLACE 21201	
46. NAME OF CEMETERY J. H. Harris		47. ADDRESS OF CEMETERY 100 N. Main St.		48. CITY OF CEMETERY Baltimore		49. STATE OF CEMETERY Md.		50. ZIP CODE OF CEMETERY 21201	
49. NAME OF INTERMENT SOCIETY J. H. Harris		50. ADDRESS OF INTERMENT SOCIETY 100 N. Main St.		51. CITY OF INTERMENT SOCIETY Baltimore		52. STATE OF INTERMENT SOCIETY Md.		53. ZIP CODE OF INTERMENT SOCIETY 21201	
54. NAME OF BURIAL PLACE J. H. Harris		55. ADDRESS OF BURIAL PLACE 100 N. Main St.		56. CITY OF BURIAL PLACE Baltimore		57. STATE OF BURIAL PLACE Md.		58. ZIP CODE OF BURIAL PLACE 21201	
59. NAME OF CEMETERY J. H. Harris		60. ADDRESS OF CEMETERY 100 N. Main St.		61. CITY OF CEMETERY Baltimore		62. STATE OF CEMETERY Md.		63. ZIP CODE OF CEMETERY 21201	
64. NAME OF INTERMENT SOCIETY J. H. Harris		65. ADDRESS OF INTERMENT SOCIETY 100 N. Main St.		66. CITY OF INTERMENT SOCIETY Baltimore		67. STATE OF INTERMENT SOCIETY Md.		68. ZIP CODE OF INTERMENT SOCIETY 21201	
69. NAME OF BURIAL PLACE J. H. Harris		70. ADDRESS OF BURIAL PLACE 100 N. Main St.		71. CITY OF BURIAL PLACE Baltimore		72. STATE OF BURIAL PLACE Md.		73. ZIP CODE OF BURIAL PLACE 21201	
74. NAME OF CEMETERY J. H. Harris		75. ADDRESS OF CEMETERY 100 N. Main St.		76. CITY OF CEMETERY Baltimore		77. STATE OF CEMETERY Md.		78. ZIP CODE OF CEMETERY 21201	
79. NAME OF INTERMENT SOCIETY J. H. Harris		80. ADDRESS OF INTERMENT SOCIETY 100 N. Main St.		81. CITY OF INTERMENT SOCIETY Baltimore		82. STATE OF INTERMENT SOCIETY Md.		83. ZIP CODE OF INTERMENT SOCIETY 21201	
84. NAME OF BURIAL PLACE J. H. Harris		85. ADDRESS OF BURIAL PLACE 100 N. Main St.		86. CITY OF BURIAL PLACE Baltimore		87. STATE OF BURIAL PLACE Md.		88. ZIP CODE OF BURIAL PLACE 21201	
89. NAME OF CEMETERY J. H. Harris		90. ADDRESS OF CEMETERY 100 N. Main St.		91. CITY OF CEMETERY Baltimore		92. STATE OF CEMETERY Md.		93. ZIP CODE OF CEMETERY 21201	
94. NAME OF INTERMENT SOCIETY J. H. Harris		95. ADDRESS OF INTERMENT SOCIETY 100 N. Main St.		96. CITY OF INTERMENT SOCIETY Baltimore		97. STATE OF INTERMENT SOCIETY Md.		98. ZIP CODE OF INTERMENT SOCIETY 21201	
99. NAME OF BURIAL PLACE J. H. Harris		100. ADDRESS OF BURIAL PLACE 100 N. Main St.		101. CITY OF BURIAL PLACE Baltimore		102. STATE OF BURIAL PLACE Md.		103. ZIP CODE OF BURIAL PLACE 21201	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7118

CERTIFICATE OF DEATH

Reg. Dist. No.

07207

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR				d. STREET ADDRESS 249 8th Street, N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) FRANCES E. TAYLOR				4. DATE OF DEATH Month JUNE Day 9 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 23, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Policewomen		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Salem, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. TAYLOR				14. MOTHER'S MAIDEN NAME ALICE A. MILLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT SISTER M. JOAN THERESE Address 4922 LaSalle Rd.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 18 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF RIGHT BREAST (1-2 YRS. DURATION)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , 1946 , to June 9 , 1958 , that I last saw the deceased alive on June 8 , 1958 , and that death occurred at 3:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Finnegan				ADDRESS (Street, city or town, state) 1746-K St., N.W., Wash. D.C. DATE SIGNED 6/9/58			
PHYSICIAN'S NAME (Type) JOHN F. FINNegan				ADDRESS (Street, city or town, state) 1746-K St., N.W., WASHINGTON, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY East Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Calmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. William Leisner ADDRESS 300-4 St. N.E. DC				24a. REC'D BY REGISTRAR JUN 11 '58		24b. REGISTRAR'S SIGNATURE Carl...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07208

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN lb 31 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hillmead Road				d. STREET ADDRESS Hillmead Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Elbert Taylor				4. DATE OF DEATH Month June Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-87		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Taylor				14. MOTHER'S MAIDEN NAME Sarah E. Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Bertram E. Taylor; Muirkirk, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease. 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 26, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Collington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

NAME OF DECEASED: John A. Wilson
AGE: 45 YEARS
SEX: Male
RACE: White
DATE OF DEATH: June 15, 1928
PLACE OF DEATH: Home
RESIDENCE: 1234 Main St., Baltimore, Md.
OCCUPATION: Engineer
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: John A. Wilson
DATE: June 15, 1928

1

DECEASED'S NAME: John A. Wilson
AGE: 45 YEARS
SEX: Male
RACE: White
DATE OF DEATH: June 15, 1928
PLACE OF DEATH: Home
RESIDENCE: 1234 Main St., Baltimore, Md.
OCCUPATION: Engineer
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: John A. Wilson
DATE: June 15, 1928

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 5204 Mineola Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Patricia Middle Jolene Last Tripi			4. DATE OF DEATH Month June Day 20 Year 1958		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-49		9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph B. Tripi			14. MOTHER'S MAIDEN NAME Edith Sullinger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Joseph Tripi; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) Bilateral lobar pneumonia (c) DUE TO (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 20, 1958	
22a. BURIAL, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/58	22c. NAME OF CEMETERY OR CREMATORY Fork Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS mt Rainier, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07210

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D. C. b. COUNTY Washington D. C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 816 K Street N E		
3. NAME OF DECEASED (Type or print) First Samuel Middle Tyndle Last Tyndle			4. DATE OF DEATH Month June 1, Day 1958- Year 19		
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH May 2, 1921		9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Lawndale N C	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Ralph Tyndle			14. MOTHER'S MAIDEN NAME Marie Haygood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W W 11		16. SOCIAL SECURITY NO. W W 11			
17. INFORMANT Address Ralph Tyndle Lawndale North Carolina					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 823x Hemorrhage and shock DUE TO (b) Crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pancreas in auto that ran off Road			
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. 6-1 1958		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 4	
20f. (City or town) Forestville P. G. Ind		20g. (State) Ind			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 1, 1958	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/2/58		22c. NAME OF CEMETERY OR CREMATORY SHELBY N.C.	
22d. LOCATION (City, town, or county) SHELBY N.C.		22e. (State) SHELBY N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS CO.		ADDRESS 1432 YOU St. NW Wash. D.C		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
24b. REGISTRAR'S SIGNATURE W. Ernest Jarvis					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

NAME OF DECEASED: *James J. Smith*
 SEX: *Male* AGE: *45* DATE OF BIRTH: *1880*
 PLACE OF BIRTH: *New York City*
 OCCUPATION: *Teacher*
 CAUSE OF DEATH: *Heart Disease*
 PLACE OF DEATH: *New York City*
 DATE OF DEATH: *1925*
 SIGNATURE OF PHYSICIAN: *John Doe*
 SIGNATURE OF REGISTRAR: *John Doe*
 OFFICIAL SEAL: *[Seal]*

1
 STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07211

7177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4114--54th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle MICHAEL Last UFFELMAN				4. DATE OF DEATH Month June Day 11th Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25th, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Operator (Gasoline)				10b. KIND OF BUSINESS OR INDUSTRY Oakdale, Penna.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Rhinehart Uffelman				14. MOTHER'S MAIDEN NAME Helen Shaffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Myrtle M. Uffelman, 4114--54th St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Kidney DUE TO (c) 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Oakdale, Penna.				20g. (County) Oakdale, Penna.			
20h. (State) Oakdale, Penna.							
21. I certify that I attended the deceased from May 15, 1958 to June 11, 1958 that I last saw the deceased alive on June 10, 1958 and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 5102 Annapolis Road, Bladensburg, Md.				DATE SIGNED 6/11/1958			
ACTUAL SIGNATURE Julius Kauffman				M.D. 5102 Annapolis Road, Bladensburg, Md.			
PHYSICIAN'S NAME (Type) Julius Kauffman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/1958		22c. NAME OF CEMETERY OR CREMATORY Montour Cemetery		22d. LOCATION (City, town, or county) Oakdale, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE Alv. Search	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1898		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF DEATH 1943		9. PLACE OF DEATH Baltimore, Md.		10. CAUSE OF DEATH Heart Disease	
11. MEDICAL HISTORY None		12. PRESENT ILLNESS None		13. DATE OF ONSET None		14. DATE OF TERMINATION None		15. PLACE OF TERMINATION None	
16. NAME OF PHYSICIAN J. H. Harris		17. NAME OF HOSPITAL None		18. NAME OF NURSE None		19. NAME OF ASSISTANT None		20. NAME OF ATTENDING None	
21. NAME OF FUNERAL HOME None		22. NAME OF CEMETERY None		23. NAME OF INTERMENT None		24. NAME OF BURIAL None		25. NAME OF CREMATION None	
26. NAME OF CORPSE None		27. NAME OF CLOTHES None		28. NAME OF SHIRT None		29. NAME OF TIE None		30. NAME OF COAT None	
31. NAME OF PANTS None		32. NAME OF SHOES None		33. NAME OF HAT None		34. NAME OF GLOVES None		35. NAME OF SOCKS None	
36. NAME OF UNDERWEAR None		37. NAME OF LINEN None		38. NAME OF BEDDING None		39. NAME OF PILLOW None		40. NAME OF BLANKET None	
41. NAME OF CLOTHES None		42. NAME OF SHIRT None		43. NAME OF TIE None		44. NAME OF COAT None		45. NAME OF PANTS None	
46. NAME OF SHOES None		47. NAME OF HAT None		48. NAME OF GLOVES None		49. NAME OF SOCKS None		50. NAME OF UNDERWEAR None	
51. NAME OF LINEN None		52. NAME OF BEDDING None		53. NAME OF PILLOW None		54. NAME OF BLANKET None		55. NAME OF CLOTHES None	
56. NAME OF SHIRT None		57. NAME OF TIE None		58. NAME OF COAT None		59. NAME OF PANTS None		60. NAME OF SHOES None	
61. NAME OF HAT None		62. NAME OF GLOVES None		63. NAME OF SOCKS None		64. NAME OF UNDERWEAR None		65. NAME OF LINEN None	
66. NAME OF BEDDING None		67. NAME OF PILLOW None		68. NAME OF BLANKET None		69. NAME OF CLOTHES None		70. NAME OF SHIRT None	
71. NAME OF TIE None		72. NAME OF COAT None		73. NAME OF PANTS None		74. NAME OF SHOES None		75. NAME OF HAT None	
76. NAME OF GLOVES None		77. NAME OF SOCKS None		78. NAME OF UNDERWEAR None		79. NAME OF LINEN None		80. NAME OF BEDDING None	
81. NAME OF PILLOW None		82. NAME OF BLANKET None		83. NAME OF CLOTHES None		84. NAME OF SHIRT None		85. NAME OF TIE None	
86. NAME OF COAT None		87. NAME OF PANTS None		88. NAME OF SHOES None		89. NAME OF HAT None		90. NAME OF GLOVES None	
91. NAME OF SOCKS None		92. NAME OF UNDERWEAR None		93. NAME OF LINEN None		94. NAME OF BEDDING None		95. NAME OF PILLOW None	
96. NAME OF BLANKET None		97. NAME OF CLOTHES None		98. NAME OF SHIRT None		99. NAME OF TIE None		100. NAME OF COAT None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 7119
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film 231 7-15-58 et
 CERTIFICATE OF DEATH

07212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4701 27th Street				e. STREET ADDRESS 4701 27th Street			
3. NAME OF DECEASED (Type or print) First WALTER Middle UTMAN Last UTMAN				4. DATE OF DEATH Month June Day 14 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1902	9. AGE (In years last birthday) 55 56 yrs.	IF UNDER 1 YEAR Months 55 Days 56 Hours 56 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant, U.S. Govt.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant, U.S. Govt.				10b. KIND OF BUSINESS OR INDUSTRY Mass.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Commodore Utman				14. MOTHER'S MAIDEN NAME Catherine Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.# 1				17. INFORMANT Chester Gierula, 13027 Matey Rd., Wheaton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 weeks				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from MAY 1 , 19 58 , to JUNE 14 , 19 58 , that I last saw the deceased alive on JUNE 13 , 19 58 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irvin M. Grassgreen				ADDRESS (Street, city or town, state) 3101 ARUNDEL RD.			
PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN				DATE SIGNED MT. RAINIER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/18/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7220

CERTIFICATE OF DEATH

Reg. Dist. No. 07213

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		c. LENGTH OF STAY IN 1b <u>Lyre</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 Woodland Road</u>				d. STREET ADDRESS <u>217 Woodland Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard F.</u> Middle <u>Valentine</u> Last <u>Valentine</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1906</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Valentine</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Reynolds</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-05-4702</u>		17. INFORMANT <u>Mrs Pauline W. Valentine</u> Address <u>217 Woodland Rd Morningside, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 MO.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>58</u> , and that death occurred at <u>2 A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene Cole</u>				ADDRESS (Street, city or town, state) <u>639 E. Capitol St. D.C.</u>			
DATE SIGNED <u>June 11 '58</u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>Eugene Cole M.D.</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Washington. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

7520

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1930</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1955</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1975</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. John Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. OFFICIAL USE <i>None</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7178

CERTIFICATE OF DEATH

07214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard R. Middle Walter Last Walter				4. DATE OF DEATH Month June Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-21	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 4 Days 8 Hours 1 Min.		IF UNDER 24 HRS. Months 4 Days 8 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer				10b. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Harvey R Walter				14. MOTHER'S MAIDEN NAME Jane Karle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 173 14 3437		17. INFORMANT Lois Walter (Wife) Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Coronary Thrombosis 420.1 DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year (c) 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 7, 1958 , to June 9, 1958 , that I last saw the deceased alive on June 9, 1958 , and that death occurred at 1:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman D. Rush M.D.				ADDRESS (Street, city or town, state) 3503 Perry St			
DATE SIGNED 6/9/58							
PHYSICIAN'S NAME (Type) Dr. N. Comeau							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 6/10/58		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORY Altoona		22d. LOCATION (City, town, or county) (State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR June 12 '58	
24b. REGISTRAR'S SIGNATURE Rebecca							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Baltimore, Md.	
7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Date of filing	
Heart disease		Natural		[Signature]		[Signature]		[Signature]		Jan 15, 1965	
13. Place of burial		14. Name of cemetery		15. Name of funeral home		16. Name of undertaker		17. Name of embalmer		18. Name of casket	
St. Mary's		St. Mary's		[Name]		[Name]		[Name]		[Name]	
19. Name of next of kin		20. Address of next of kin		21. Telephone number of next of kin		22. Name of physician		23. Address of physician		24. Telephone number of physician	
[Name]		[Address]		[Phone]		[Name]		[Address]		[Phone]	
25. Name of registrar		26. Address of registrar		27. Telephone number of registrar		28. Name of informant		29. Address of informant		30. Telephone number of informant	
[Name]		[Address]		[Phone]		[Name]		[Address]		[Phone]	

FILED
BOMID
1965

7221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>7676 Walters Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hellie Irene Walter</u>				4. DATE OF DEATH <u>June 13 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William J Gray</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic myocarditis</u> DUE TO (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>unknown</u> <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>June 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				DATE SIGNED <u>6/13/58</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C VAN Natta</u>				<u>Washington 28 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-16-1958</u>		<u>Epiphany</u>		<u>Forestville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Mattingly</u>				24a. REC'D BY REGISTRAR <u>Washi D.C</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHELTENHAM				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS A.F. Base				d. STREET ADDRESS 102 WESTWOOD DR.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE OLIVER WARNER				4. DATE OF DEATH Month Day Year JUNE 27 1958			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 21 1916		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PILOT USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE O. WARNER				14. MOTHER'S MAIDEN NAME GRACE C. BRADY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 153-20-6240		17. INFORMANT Address USAF Personnel Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CORONARY occlusion with 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Myocardial infarction DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from D.O.A. , 19____, to JUNE 27 , 19 58 , that I last saw the deceased alive on _____, 19____, and that death occurred at 1:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Weber				ADDRESS (Street, city or town, state) 1001st USAF HOSP		DATE SIGNED JUNE 27, 58	
PHYSICIAN'S NAME (Type) RICHARD H. WEBER				ANDREWS A.F. Base Wash 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. 517-11th St. S.E.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I, the undersigned do hereby certify that while in performance of my duties as Medical Officer of the Day at 1001st USAF Hospital, Andrews Air Force Base, Washington 25, D.C. I received a call from wife of deceased, describing severe chest pains and requesting medical advice. I immediately dispatched an ambulance to home of deceased and had him transported to this facility, pronouncing him dead on arrival at 1:55 a.m.

Richard H. Weber
RICHARD H. WEBER
CAPT, USAF (MC)
Attending Physician

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Samuel</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4-1 Samuel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>515-8th Street</u>			d. STREET ADDRESS <u>515-8th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Eleanor Bernadette Wattens</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-19</u>	9. AGE (In years and birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sidney Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Sadie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Joseph C. Wattens - Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary embolism</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 23, 1958</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National,</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24. REC'D BY REGISTRAR <u> </u>	
24a. DATE <u>JUN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>			

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
BIRTH RECORD

1923

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
BIRTH RECORD

1923

Form with multiple sections for recording birth data, including fields for name, date, sex, and parental information. The form is partially filled out with handwritten text.

NAME: *John J. Smith*

DATE OF BIRTH: *Jan 15 1923*

SEX: *Male*

PARENTS: *John J. Smith & Mary J. Smith*

RESIDENCE: *123 Main St, New York City*

PHYSICIAN: *Dr. J. H. Jones*

CHURCH: *St. John's Church*

RELIGION: *Catholic*

EDUCATION: *High School*

OCCUPATION: *Student*

STATUS: *Single*

REMARKS: *Normal birth, no complications.*

7224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights				c. LENGTH OF STAY IN TB 35 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4808- V. Street S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERBERT WEBSTER				4. DATE OF DEATH June 1st. 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9th. 1887	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.O. Gov. Mechanic		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Webster				14. MOTHER'S MAIDEN NAME Ann J. Savage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Nola B. Webster 4808- V. Street S.E. (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA to BRAIN 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic CARCINOMA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4/18/58 1 year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural Effusion						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/18 , 19 58 to 5/31 , 19 58 , that I last saw the deceased alive on 5/31 , 19 58 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4400- Bowen Road S.E. DATE SIGNED June 1st 58							
ACTUAL SIGNATURE Thomas F. Cullen				M.D. 4400- Bowen Road S.E.			
PHYSICIAN'S NAME (Type) THOMAS F. CULLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial June 4-58		June 4-58		Cedar Hill Cemetery		Smithland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1661- grand Hwy. Rd		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
						24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased George Webster		Sex Male		Age 75 Years		Date of Birth June 2nd 1849	
Place of Birth Washington, D.C.		Race White		Marital Status Married		Date of Marriage June 1st 1870	
Residence at Date of Death 4800 - V. Street S.E.		Cause of Death Heart Disease		Place of Death Home		Date of Death June 1st 1924	
Signature of Physician George Webster		Signature of Registrar George Webster		Signature of Coroner George Webster		Signature of Burial Officer George Webster	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7179

CERTIFICATE OF DEATH

Reg. Dist. No.

07219

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elvira Middle M.M.N. Last Wells		4. DATE OF DEATH Month June Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Dec. 1896
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months 4 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mardie Wells		Address 1409-50th Ave. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis & abscess 181.7 DUE TO formative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the urethra DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2.00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis B. Bachrach M.D.		ADDRESS (Street, city or town, state) 915-19th St N.W. Wash. D.C.	
DATE SIGNED 7/4/58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-7-58	22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem.	22d. LOCATION (City, town, or county) (State) Bladensburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc		ADDRESS 577-11th St S.E.	
24a. REC'D BY REGISTRAR DATE JUN 6 '58		24b. REGISTRAR'S SIGNATURE W.D. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 10/57

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 2507 Bucklodge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Frank First MARTIN Middle Williams Last			4. DATE OF DEATH Month June Day 14 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-58		9. AGE (In years last birthday) yrs. 12 Months 12 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Walter Williams			14. MOTHER'S MAIDEN NAME Martha Jane Storm		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Walter F. Williams—Same as Item #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Birth injury DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 12 days 12 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 6-2 , 19 58 , to 6-14 , 19 58 , that I last saw the deceased alive on 6-14 , 19 58 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE R.D. Baker M.D.		ADDRESS (Street, city or town, state) 2513 Bucklodge Rd.		DATE SIGNED 6-14-58	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		R.D. Baker, M.D.		Adelphi Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7225
CERTIFICATE OF DEATH

07221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 2370 Champlain St., N.W. Apt#36	
3. NAME OF DECEASED (Type or print) First Middle Last Gilbert B. Wilson		4. DATE OF DEATH Month Day Year 6 5 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED, not legally WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/13
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		9. AGE (In years last birthday) 44 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Burlington Hotel		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Clarence G. Wilson		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Ethel Pate		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -	
16. SOCIAL SECURITY NO. 577-18-3166		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Myocardial infarction (b) Atherosclerotic Heart Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS, BRONCHIAL ASTHMA, COR PULMONALE, HEMORRHAGIC PANCREATITIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/25, 1957, to 6/5, 1958, that I last saw the deceased alive on 6/5, 1958, and that death occurred at 3:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		DATE SIGNED 6/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/6/58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McHenry		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
ADDRESS 1820 9th St. N.W.		24b. REGISTRAR'S SIGNATURE W. Beach	

CERTIFICATE OF DEATH

1935

1. PLACE OF DEATH Home		2. SEX Male		3. AGE 45		4. RACE White		5. OCCUPATION Teacher	
6. MARITAL STATUS Married		7. DATE OF BIRTH 1900		8. PLACE OF BIRTH Maryland		9. US BORN Yes		10. FOREIGN BORN No	
11. DECEASED Yes		12. DATE OF DEATH 1935		13. TIME OF DEATH 10:00 AM		14. PLACE OF DEATH Home		15. CAUSE OF DEATH Heart Disease	
16. DISEASE Heart Disease		17. SYMPTOMS Chest pain, shortness of breath		18. MEDICAL HISTORY Hypertension, diabetes		19. PRESENT ILLNESS Worsening chest pain		20. TREATMENT Medication, rest	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF PHYSICIAN [Signature]		24. SIGNATURE OF REGISTRAR [Signature]		25. SIGNATURE OF CLERK [Signature]	
26. DATE OF DEATH 1935		27. TIME OF DEATH 10:00 AM		28. PLACE OF DEATH Home		29. CAUSE OF DEATH Heart Disease		30. DISEASE Heart Disease	

RECEIVED BY CLERK

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the place where the death occurred.

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4
X
77
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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 15 Film 230 6-18-58 et

07222

7181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Genral Hosital				d. STREET ADDRESS 1013 58th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Wilson Last				4. DATE OF DEATH Month June Day 6 Year 19 58			
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Nov 1889		9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian, School			10b. KIND OF BUSINESS OR INDUSTRY Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Dick Wilson				14. MOTHER'S MAIDEN NAME Emma P. (Maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebral infarcts DUE TO 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudo carditis DUE TO Carcinoma of the body of the pancreas (c) 1yr.							INTERVAL BETWEEN ONSET AND DEATH 41 days 41 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/26 , 19 58 to 6/6 , 19 58 that I last saw the deceased alive on 6/6 , 19 58 , and that death occurred at 4.00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman D. Comeau		M.D. 3503 Perry St.		ADDRESS (Street, city or town, state) 24 T Romaine Rd		DATE SIGNED 6/6/58	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, county) (State) Washington D.C.			
Robert G. Mason Funeral Home, Inc 2500 Nichols Ave, S.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE JUN 12 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

1997

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		MARYLAND c. LENGTH OF STAY IN 1b Dead on arrival		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY N. E. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1701 M st., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Glentina Ella Frazier Woods		4. DATE OF DEATH Month Day Year June 15 1958			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 March		9. AGE (in years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Henry Simms		14. MOTHER'S MAIDEN NAME Annie Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 578058209		17. INFORMANT Albert B. Frazier 1606 Indiana Ave., S.E. Washington, D. C. Son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that ran off road and struck tree			
20c. TIME OF INJURY Hour 9:30 p. m. Month, Day, Year 6/16 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tucker Road		20f. (City or town) (County) (State) Oxon Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 16, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Stewart		24a. REC'D BY REGISTRAR DATE JUN 18 '58	
24b. REGISTRAR'S SIGNATURE Overman					

1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

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Figure 3

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[illegible]

books and articles

James Bonar

June 16, 1958